

**MEDICAL HISTORY - MALE**

Date: _____

Last name:		First name:	
Date of birth:		City of birth:	
Street, no.:		Zip code, city:	
Health insurance:		Profession	
Tel. no.:		Cell phone no.:	
e-mail:		Nationality:	
Height:	Weight:	Married with this partner? yes <input type="checkbox"/> no <input type="checkbox"/>	
Do you smoke? yes <input type="checkbox"/> if yes, what and how many a day: _____		no <input type="checkbox"/>	
Do you drink alcohol? never <input type="checkbox"/> rarely <input type="checkbox"/> sometimes <input type="checkbox"/> frequent <input type="checkbox"/>			
Your treating family doctor: _____			
Your treating urologist: _____			
Are you healthy: yes <input type="checkbox"/> no <input type="checkbox"/>			
If no, which illness do you have? _____			
Remarks: _____			
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Thyroid dysfunction	<input type="checkbox"/> Gastro-intestinal disease	
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Nephropathy, adrenopathy, liver disease		
Carcinosis:			
Other diseases:			
Do you have to take drugs regularly? yes <input type="checkbox"/> no <input type="checkbox"/>			
If yes, which ones: _____			
Have you ever used anabolic steroids? yes <input type="checkbox"/> no <input type="checkbox"/>			
Did you already have a test for mucoviscidosis / cystic fibrosis before? yes <input type="checkbox"/> no <input type="checkbox"/>			
Result: _____			
Did you already have a genetic counseling or chromosomal analysis before? yes <input type="checkbox"/> no <input type="checkbox"/>			
Result: _____			
Did you already have operations? yes <input type="checkbox"/> no <input type="checkbox"/>			
If yes, which ones and when: _____			

Last name:	First name:
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Do you know of any allergies you have: no yes
If yes, which ones: _____

Do you suffer from erectile dysfunction?: no yes
Do/did you suffer from testicular lesions? no yes
Undescended testes as a child? no yes
Did you suffer from testicular cancer? no yes
Do/did you suffer from testicular varicoceles?no yes
Did you suffer from mumps as a child? no yes

Have there been previous pregnancies? no yes
with a different partner? no yes
If yes, result of the pregnancy: _____

Last visit at the urologist's on (date): _____
Semen analysis? no yes
If yes: when _____
and result: _____
Ultrasound examination of the testes?: no yes
If yes: when _____
and result: _____

Unprotected sex since: _____
Problems when having sex? no yes
Have you had yourself sterilized? no yes

Have there been any of the following chronic diseases in your family,
e.g. siblings, parents or grandparents? no yes
Cancer/other tumors _____
Genetic diseases _____
Cardiac or circulatory troubles _____
Others _____



Last name:	First name:
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The examination of Anti-HIV-1,2, HBs-AG, Anti-HBc, Anti-HCV-Ab and, in few cases, of further parameters, is required by the German "Gemeinsamer Bundesausschuss" according to the guidelines on Assisted Reproduction following the specifications of the German Transplantation Act/Ordinance on tissues and organs (TPG-GewV) dated from July 16th, 2009 and August 21st, 2014.

In Annex 3 of the ordinance about the requirements for quality and security regarding the removal of tissues and their transplantation according to the German Transplantation Act is determined explicitly, which laboratory tests and methods of examination have to be performed necessarily.

I do agree that my blood will be analyzed regarding blood count, basic hormones and a possible infection with hepatitis and/or HIV. The latter two examinations have to be repeated every year.

I am aware that costs for these examinations may not be covered by my health insurance.

I do agree that my medical data and the results of my treatment(s) are reported to the German IVF Register (DIR) in an anonymous form for statistical purposes.

I do agree that if my bills will not be paid in time my personal data may be given to a lawyer or a collection agency.

I confirm the information given above to be true to the best of my knowledge.

Stuttgart, _____

date

signature