Date first appointment:	Doctor:	Referral doctor:

Please fill in the following fields or check the relevant fields.
If any questions are not clear, please put a question mark by them.

Surname:	
First name(s):	
Birth name:	
Place of birth:	
Address:	
Telephone:	
Profession:	

1 **Date of birth:** ..... **Age:** .....

2 **Are you married to each other?** ◯ yes ◯ no

How long have you been in this marriage (partnership) ..... (Date)

3 **Have you already achieved a pregnancy?**

☐ yes, with my current partner **When?** .....

- After fertility treatment? ◯ no ◯ yes

☐ yes, with another partner **When?** .....

- After fertility treatment? ◯ no ◯ yes

Have you already had unwanted childlessness with a previous partner?

◯ no ◯ yes

4 **Have you already seen an andrologist?**

◯ no ◯ yes **(when was the last time?)** .....

- What was the result? ☐ Normal ☐ Abnormal

Did your andrologist prescribe any medication for you?

◯ no ◯ yes **(what?)**

.....

5 **Have you been sterilised?**

◯ no ◯ yes **(when?)** .....

- If yes, did you have this procedure reversed?

◯ no ◯ yes **(when?)** .....

6 **Have you ever had s semen analysis?**

◯ no ◯ yes **(when was the last time?)** .....

- What was the result? ☐ normal ☐ abnormal

7 **Do you suffer from erectile dysfunction?** ◯ no ◯ yes

Have you ever suffered from any chronic diseases, metabolic or hormonal dysfunction?

◯ no ◯ yes

- If so, what were they?

.....

.....

8 **Have you suffeered testicular injury?**

◯ no ◯ yes **(when?)** .....

- If yes, what treatment did you have?

.....

As a child did you have undescended testicles?

☐ no ☐ yes: left ☐ yes: right

- If yes, what treatment did you have?

☐ None ☐ Hormone treatment ☐ Surgery

Have you suffered from testicular inflammation?

◯ no ◯ yes **(when?)** .....

- If yes, what treatment did you have?

.....

Have you had testicular cancer?

☐ no ☐ yes: left ☐ yes: right

- when? Left: ..... Right: .....

- What treatment did you have?

.....

.....

Have you suffered from varicocele?

◯ no ◯ yes

- If yes, have you had surgery for it?

◯ no ◯ yes **(when?)** .....

Have any tissue samples been taken from your testicles?

☐ no ☐ yes, left ☐ yes, right

- when? left: ..... right: .....

- What was the result? ☐ Normal ☐ Abnormal

9 **Have you ever had surgery on the lower abdomen or genital area?**

◯ no ◯ yes **(what?)**

	Year

Surname:	
First name(s):	
Date of birth:	

10 Which medication are you currently taking?

---

11 Has a problem been found in regards to your vas deferens?

☐ no ☐ yes, left ☐ yes, right

12 Have you had a prostate examination?

○ no ○ yes **(when?)** ---

- What was the result? ☐ normal ☐ abnormal

13 Tell us about your weight and height?

Weight (kg): ---- Height (cm): ----

Have you had weight fluctrations (> 4 kg)?

☐ no ☐ yes, weight increase ☐ yes, weight loss

14 How many meals do you eat a day?

○ 1-2 ○ 3-4 ○ more than 4

What diet do you adhere to?

○ Mixed ○ vegetarian ○ unbalanced

15 Do you practise any sports?

○ never ○ rarely ○ occasionally ○ regularly

- If yes, which sports do you do?

---

16 Do you drink alcohol?

○ never ○ rarely ○ occasionally ○ regularly

Do you smoke?

○ no ○ 1-5 Zig./Tag

○ 6-10 cig./day ○ 11-15 Zig./Tag

○ 16-20 cig./day ○ more than 20 **(number?)** ---

Do you take any other drugs?

○ no ○ yes

- which ones? ---

- how often? ---

Do you use stimulants or doping substances?

○ no ○ yes

17 In your everyday life, are you subjected to physical stresses?

☐ No	☐ Shift work
☐ Noise	☐ Lack of daylight
☐ Heat	☐ Cold
☐ Dust	☐ Severe physical strain
☐ Chemicals	☐ Gases/aerosols

Which toxic substances are they?

---

18 Do you suffer from any allergies?

○ no ○ yes **(which?)**

Are you especially allergic to penicillin?

○ no ○ yes

Which medication do you take for your allergies?

---

19 Do you suffer from any of the following conditions? ☐ no

	slight	moderate	severe
Insominia / restlessness at night	☐	☐	☐
General tiredness/Performance drop	☐	☐	☐
Stress (general)	☐	☐	☐
Stress (at work)	☐	☐	☐
Partner problems	☐	☐	☐
Anxiety depression	☐	☐	☐
Mental illness	☐	☐	☐

20 Have you ever had any of the following diseases? ☐ no

(since) Year

Mumps ----

Diabetes ----

- Insulin-dependent? ☐ yes ☐ no

High blood pressure ----

Epilepsy ----

Cancer / other tumours ----

- which? ---

Thyroid disease ----

21 Are you taking thyroid medication?

○ no ○ yes **(which?)**

Surname:	
First name(s):	
Date of birth:	

22 **Do you suffer from any other diseases and which medication do you take for them?**

◯ no ◯ yes **(which?)** **Medication**

---

23 **Are there any hereditary diseases in your family Such as cancer, other problems or unwanted childlessness?**

☐ no

☐ yes, mother´s side **(which?)**

☐ yes, father´s side **(which?)**

---

24 **Are you a carrier or have you had contact with anyone suffering from multi-resistant pathogens, such as MRSA?**

◯ no ◯ yes

25 **Have you ever undergone a chromosome test?**

◯ no ◯ yes

- What was the result?

☐ normal ☐ abnormal

26 **Have you ever had a genetic test for cystic fibrosis (CFTR)?**

◯ no ◯ yes

- What was the result?

☐ normal ☐ abnormal

27 **Who is your treating physician?**

Who is your andrologist?

Comments:

⇩ **Part filled in by the doctor at the fertility clinic** ⇩

Sterilisation	O yes	O no
ART main indication	O female	O male
	O both	O idiopathic

Sperm analysis results

O Normozoospermia	O Asthenozoospermia
O Oligozoospermia	O Teratozoospermia
O Necrozoospermia	O Leukozoospermia
O OAT °I	O Azoospermia
O OAT °II	O Aspermia
O OAT °III	

Testicles

O Negativ	O Trauma
O Inflammation	O Undescended
O Torsion	O Hypoplasia
O Atrophy	O Neoplasia

Prostate

O Negative	O Hyperplasia
O Inflammation	O Neoplasia

Other

O Spermatocele	O Hydrocele	O Varicocele
O CAVD unilateral	O CAVD bilateral	

Surname:	
First name(s):	
Date of birth:	

Planned sperm collection

O Antegrade ejaculation O Retrograde ejaculation
O Epididymal sperm O Testicular sperm
O MESA both sides O TESE both sides
O MESA one side O TESE one side
O Electrostimulation
O Thaw O Cryopreservation

Infection serology

O HIV O HBV O HCV O TP O Chlam.

Basal hormones

O FSH O LH O TSH O TESTO O DHEAS
O E2 O HCG O PRG O PRL

Genetics

O Cytogram O CFTR O AZF

O Arrange sperm analysis

O Refer to urology
O Refer to anaesthesia
O Refer to human genetics