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] **Since when have you wanted to have children?**

..... (month, year)

How often do you have sexual intercourse with your partner?

approx. ..... time per week

approx. ..... times per month

[4] **Have you ever undergone medical treatment to have a child?**

◯ no ◯ yes, since ..... (year)

- If yes, how many doctors have you contacted?

..... doctors

Type of treatment	Number of cycles	Pregnancy
Cycle control with intercourse At the time of ovulation	.....	◯ yes ◯ no
Stimulation of the ovaries - with intercourse at the time of ovulation	.....	◯ yes ◯ no
Insemination - with the sperm of partner	.....	◯ yes ◯ no
Insemination - with the sperm of a donor	.....	◯ yes ◯ no
In vitro fertilisation (IVF)	.....	◯ yes ◯ no
Intracytoplasmic sperm Injection (ICSI)	.....	◯ yes ◯ no
Thaw cycle (cryotransfer)	.....	◯ yes ◯ no
GIFT	.....	◯ yes ◯ no
Other	.....	◯ yes ◯ no

[5] **In the event of previous stimulations of the Ovaries or inseminations:**

Which medications did you take?

.....

.....

Were there any complications

☐ No ☐ Hyperstimulation syndrome

☐ Bleeding ☐ Other **(which?)**

.....

.....

[6] **Previous IVF or ICSI treatments*:**

** if you have already had more than four IVF or ICSI treatments, please state the last four.*

#	Year	IVF	ICSI	Number of oocytes retrieved	Number of embryos transferred	Number frozen	Pregnancy
1	.....	◯	◯	.....	.....	.....	◯ yes ◯ no

Which medications did you take for this?

.....

#	Year	IVF	ICSI	Number of oocytes retrieved	Number of embryos transferred	Number frozen	Pregnancy
2	.....	◯	◯	.....	.....	.....	◯ yes ◯ no

Which medications did you take for this?

.....

#	Year	IVF	ICSI	Number of oocytes retrieved	Number of embryos transferred	Number frozen	Pregnancy
3	.....	◯	◯	.....	.....	.....	◯ yes ◯ no

Which medications did you take for this?

.....

#	Year	IVF	ICSI	Number of oocytes retrieved	Number of embryos transferred	Number frozen	Pregnancy
4	.....	◯	◯	.....	.....	.....	◯ yes ◯ no

Which medications did you take for this?

.....

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

Were there any complications with the IVF/ICSI treatments?

☐ no ☐ Hyperstimulation syndrome
☐ Bleeding ☐ Other **(which?)**

---

7 **Have your fallopian tubes already been checked?**

◯ no ◯ yes **(when?)** ---

- If yes, which method was used?

☐ Ultrasound ☐ X-ray ☐ Laparoscopy

- what was the result?

Left fallopian tube ◯ Open ◯ Blocked
Right fallopian tube ◯ Open ◯ Blocked

8 **Have you already had surgery of the abdomen or lower abdomen?**

◯ no ◯ yes **(what?)** **Year**

---

9 **When was your last cancer screen?**

--- (Year)

When was your last mammogram?

--- (Year)

10 **Have you already been pregnant?**

◯ no ◯ yes

- If yes, how long has it been since the pregnancy started?

--- Mounths

Year	Birth (B)? Miscarriage (M)? Termination (T)?	With the current partner?	After fertility treatment?
---	◯ B ◯ M ◯ T	◯ yes ◯ no	◯ yes ◯ no
---	◯ B ◯ M ◯ T	◯ yes ◯ no	◯ yes ◯ no
---	◯ B ◯ M ◯ T	◯ yes ◯ no	◯ yes ◯ no
---	◯ B ◯ M ◯ T	◯ yes ◯ no	◯ yes ◯ no

Were there any complications? ◯ no ◯ yes

11 **At what age did you start having your period?**

At the age of ---

At what age did you start to develop breasts? At the age of…

At what age did you start to have underarm and pubic hair? At the age of…

12 **How regular were your monthly periods during the first years of puberty?**

- on average every --- to --- days

☐ I have never had spontaneous periods.

13 **Have you ever used contraception?**

Pill: ◯ no ◯ yes: from --- to ---

Coil: ◯ no ◯ yes: from --- to ---

Have you been sterilised?

◯ no ◯ yes **(when?)** ---

Were there any complications?

◯ no ◯ yes **(which?)**

---

14 **Have you ever measured your basal temperature to determine when you are fertile?**

◯ no ◯ yes

- What was the result?

◯ normal ◯ abnormal

15 **How long between the first day of your period And the first day of the following period (cycle duration)?**

◯ Regularly between --- and --- days
◯ Irregularly between --- and --- days
◯ I have not had a period for
since --- ◯ days ◯ weeks ◯ mounths

16 **How long does your period last on average?**

- Between --- and --- days

How heavy is your period?

◯ Light ◯ Moderate ◯ Heavy

Have you ever had bleeding between periods? ◯ no ◯ yes

- Spotting before or after your periods? ☐ yes, before ☐ no ☐ yes, after

Date of last period? ---

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

17 Do you suffer from pain during your periods?

◯ no ◯ Light ◯ Moderate ◯ Heavy

How often? ◯ rarely ◯ occasionally ◯ always

Do you take painkillers? ◯ no ◯ yes

When does the pain start?

◯ before . . . ◯ when . . . bleeding starts

When is the pain worst?

◯ before . . . ◯ when . . . bleeding starts

Have you had pain since your first period?

◯ no ◯ yes

18 Do you have any other pain in the lower abdomen?

◯ no ◯ rarely ◯ often ◯ all the time

Do you suffer from pain when you pass water? ◯ no ◯ yes

Do you suffer from pain when you pass stool? ◯ no ◯ yes

Is there blood in your urine? ◯ no ◯ yes

Is there blood in your stool? ◯ no ◯ yes

Is sexual intercourse painful? ◯ no ◯ yes

19 Do you notice any of the following symptoms Before your period starts? ☐ no

	light	moderate	heavy
Bloated/full feeling	☐	☐	☐
Feeling low / depression	☐	☐	☐
Migraine	☐	☐	☐
Weight gain	☐	☐	☐
Swelling of the hands/feet	☐	☐	☐
Breats soreness/sensitive nipples	☐	☐	☐

20 Have you, besides time periods when you were pregnant or breastfeeding, noticed secretions from your breasts?

◯ no ◯ yes ◯ yes, but only after provocation

- since when? ----------

- on which side? ☐ one side ☐ both sides

- what colour is it? ----------

21 Do you suffer from any of the following symptoms? ☐ no

Acne: slight ☐ moderate ☐ severe ☐

- since when? ----------

- where? ☐ Face ☐ Back ☐ Chest

Increased hair loss slight ☐ moderate ☐ severe ☐

- since when? ----------

Increased body hair slight ☐ moderate ☐ severe ☐

- since when? ----------

- where? ☐ Face ☐ Back ☐ Chest ☐ Legs ☐ Arms ☐ Stomach

22 Tell us about your weight and height

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

Have you had weight fluctuations (> 4 kg)?

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

23 How many meals do you eat a day?

◯ 1-2 ◯ 3-4 ◯ more than 4

What diet do you adhere to?

◯ mixed ◯ vegetarian ◯ unbalanced

24 Do you practice any sports?

◯ never ◯ rarely ◯ occasionally ◯ regularly

- if yes, which sports do you do?

---

25 Do you drink alcohol?

◯ never ◯ rarely ◯ occasionally ◯ regularly

Do you smoke?

◯ no ◯ 1-5 cig./day

◯ 6-10 cig./day ◯ 11-15 cig./day

◯ 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

26 In your everyday life, are you subjected to physical stress?

☐ No ☐ Shift work

☐ Noise ☐ Lack of daylight

☐ Dust ☐ Severe physical strain

☐ Chemicals ☐ Gases/aerosols

Which toxic substances are they?

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

27 **Do you suffer from allergies?**

○ no ○ yes **(which?)**

Are you allergic to penicillin?

○ no ○ yes

Which medication do you take for your allergies?

---

28 **Have you ever had any of the following diseases or conditions?** ☐ no

(since) year

Diabetes ---
- Insulin-dependent? ☐ yes ☐ no

Epilepsy ---
Lower abdominal problems ---
Asthma / chronic bronchitis ---
Abdominal/intestinal disease ---
Kidney disease ---
Adrenal gland disease ---
Liver disease ---
Cardiovascular disease ---
Cancer / other tumors? ---
- which? ---
Headaches ---
Migraine ---

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

	slight	moderate	severe
Insomnia / restlessness at night	☐	☐	☐
General tiredness/performance drop	☐	☐	☐
Irritability / nervousness	☐	☐	☐
Stress (general)	☐	☐	☐
Stress (at work)	☐	☐	☐
Partner problems	☐	☐	☐
Anxiety / depression	☐	☐	☐
Mental illness	☐	☐	☐
Hot flushes / outbreaks of sweating	☐	☐	☐
Patchy red skin	☐	☐	☐
Vaginal dryness	☐	☐	☐
Palpitations	☐	☐	☐
Thrombosis	☐	☐	☐
Highblood pressure	☐	☐	☐

	slight	moderate	severe
Varicose veins	☐	☐	☐
Ovarian cysts	☐	☐	☐

30 **Have you had a thyroid test?**

○ no ○ yes **(when?)** ---

- If yes, which method was used?

☐ Ultrasound ☐ X-ray ☐ Blood Test

- What was the result?

☐ Unknown ☐ Negativ ☐ Abnormal

- If abnormal, what was the result?

Do you take thyroid medication?

○ no ○ yes **(what?)**

---

31 **Have you had any surgery in the abdomen or lower abdomen before?**

○ no ○ yes **(what?)**	**Year**
---	---
---	---
---	---
---	---

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

○ no ○ yes **(what?)**	**Medication**
---	---
---	---
---	---
---	---

33 **Are there any hereditary diseases in your family, Cancer, other problems or unwanted childlessness?**

☐ no

☐ yes, mother´s side **(what?)**

☐ yes, father´s side **(what?)**

---

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

○ no ○ yes

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

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

O no O yes

- What was the result?

☐ normal ☐ abnormal

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

O no O yes

- What was the result?

☐ normal ☐ abnormal

37 **Have you been vaccinated against rubella?**

O no O yes

38 **Who is you treating physician?**

Who is your gynaecologist?

Comments:

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

Sterilisation	O yes	O no

Indications	**+ Relevance -**		
None known	O	O	O
Tubal	O	O	O
Endometriosis	O	O	O
Path. Tubal factor	O	O	O
Dysmucorrhea	O	O	O
Sperm antibodies (F)	O	O	O
Path. cycle	O	O	O
Amenorhoea	O	O	O
Oligomenorrhoea	O	O	O
Anovulation	O	O	O
Luteal phase defect	O	O	O
PCO	O	O	O
Hyperandrogenaemia	O	O	O
Hyperprolactinaemia	O	O	O
Unknown	O	O	O
Misc.	O	O	O

ART main indication	O female	O male	
	O both	O idiopathic	

Planned treatment

O Monitoring with VZO	O OS with VZO
O IUI	O AID
O IVF	O ICSI
O IVF + ICSI	O Cryotransfer
O GIFT	O

Sperm

O ejaculate O epididymal O testikular
O single OP O double OP
O Thaw O Cryopreservation
O Arrange semen analysis appointment

 # Embryos for ET O 1 O 2 O 3

Cryo pronuclei desired?

O no O yes, from ☐ pre-nuclei

Infection serology

O HIV O HBV O HCV O TP O Chlam.
O Rubella

Basal hormones

O FSH O LH O TSH O TESTO O DHEAS
O E2 O HCG O PRG O 17-OH-P
O Androstendione O PRL

Smear

O Fungus O Bact. O Chlam. O Mycopl.

Genetics

O Cytogram O CFTR O AZF

O Transfer to anaesthesia
O Transfer to human genetics