MEDICAL HISTORY - FEMALE

kinderwunschzentrum STUTTGART
PRAXIS VILLA HAAG
DR. MED. D.B. MAYER-EICHBERGER

Date: _____

Last name:	First name:	
Date of birth:	Maiden name:	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 ☐ no ☐
Do you smoke? yes ☐ if yes, what and how many a day: _____ no ☐		
Do you drink alcohol? never ☐ rarely ☐ sometimes ☐ regularly ☐		

Your treating family doctor: _____

Your treating gynecologist: _____

Shall we send a report of the treatment(s) to your gynecologist? yes ☐ no ☐

Are you healthy: yes ☐ no ☐

If no, which illness do you have? _____

Remarks: _____

☐ Diabetes	☐ Thrombosis	☐ Asthma
☐ Epilepsy	☐ Thyroid dysfunction	☐ Gastro-intestinal disease
☐ Cardiovascular disease	☐ Nephropathy, adrenopathy, liver disease	
Carcinosis:		
Other diseases:		

Do you have to take drugs regularly? yes ☐ no ☐

If yes, which ones: _____

Genetic counselling	yes ☐	no ☐	
Chromosomal analysis	yes ☐	no ☐	result: _____
Test for mucoviscidosis / cystic fibrosis	yes ☐	no ☐	result: _____

Did you already have operations? yes ☐ no ☐

If yes, which ones and when:
_____

Test of tubal patency?: no ☐ yes ☐
If yes, when:_____ which method: laparoscopy ☐ ultrasound ☐
Tubes patent (left/right)?: no ☐ ☐ yes ☐ ☐

Allergies: no ☐ yes ☐
If yes, which ones: _____

Previous infertility treatments: no ☐ yes ☐
If yes, which ones:
Cycle monitoring and timed intercourse no ☐ yes ☐ _____ cycles
Stimulation of ovaries with pills or injections no ☐ yes ☐ _____ cycles
Insemination no ☐ yes ☐ _____ cycles
IVF treatments no ☐ yes ☐ _____ cycles
ICSI treatments no ☐ yes ☐ _____ cycles
Cryo cycles no ☐ yes ☐ _____ cycles

Previous pregnancies no ☐ yes ☐
Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐
Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐
Year: _____ result of pregnancy: _____ prev. partner ☐ current partner ☐

Last menstruation on (date): _____
Bleeding every _____ days Duration of bleeding _____ days
Pain during menstruation: no ☐ yes ☐
Mid-cycle bleeding: no ☐ yes ☐
Last appointment at your gynecologist's? _____

Unprotected sex since: _____
Problems when having sex? no ☐ yes ☐
Contraceptive pill? no ☐ yes ☐
If yes, when and how long: _____
Contraceptive coil (IUD) or injection? no ☐ yes ☐
If yes, when and how long: _____
Have you had yourself sterilized? no ☐ yes ☐

The details of laboratory examination of blood for Anti-HIV-1,2, for Anti-HBc and for Anti-HCV-Ab, in special cases also for more examinations, are regulated in a German paper called "Richtlinien über die künstliche Befruchtung" according to the German tissue transplantation law (TPG-GewV) dating from August 21st, 2014. In another paper regarding quality and security in taking human tissue and

transplanting it according to the TPG-GewV is regulated, which laboratory examinations by which methods are obligatory.

Last name:	First name:

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 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 in case 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