

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"/> regularly <input type="checkbox"/>			

Your treating family doctor: _____

Your treating urologist: _____

Are you healthy: yes no

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 no

If yes, which ones: _____

Have you ever used anabolic steroids? Yes no

Genetic counselling	yes <input type="checkbox"/>	no <input type="checkbox"/>	
Chromosomal analysis	yes <input type="checkbox"/>	no <input type="checkbox"/>	result: _____
Test for mucoviscidosis / cystic fibrosis	yes <input type="checkbox"/>	no <input type="checkbox"/>	result: _____

Did you already have operations? no yes
If yes, which ones and when: _____

Allergies: 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
If yes: left side right side both sides
Did you suffer from mumps as a child? no yes

Have there been previous pregnancies no yes
 with a different partner no yes
Year: _____ result of pregnancy: _____ prev. partner current partner
Year: _____ result of pregnancy: _____ prev. partner current partner

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

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.

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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 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