Kinderwunschzentrum an der Gedächtniskirche, Dr. med. Matthias Bloechle und Dr. med. Silke Marr,
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FB Medical history form

- Please fill out this document as completely and legibly as possible.
- Please bring the following with you to the first appointment: ID card, vaccination certificate, blood group certificate (if available)

Last Name, First Name:	
Date of birth:	
Height and weight:	_____ m / _____ kg
Do you have any known allergies? IMPORTANT: against antibiotics?	No ☐ Yes ☐ If yes, please specify:
Do you have a thyroid disease?	No ☐ Yes ☐ If yes, please specify:
Do you smoke?	No ☐ Yes ☐ If yes, how much:
Do you drink alcohol?	No ☐ Yes ☐ If yes, please specify: often / occasionally / rarely
Since when you have a desire to have children?	
Have you been pregnant before?	No ☐ Yes ☐ If yes, please specify number of: previous pregnancies_____/births____/miscarriages____
Have you been pregnant with your current partner?	No ☐ Yes ☐
Are you married?	No ☐ Yes ☐ If yes, since when:
Is your cycle regular (every 26 to 35 days with bleeding for 3-5 days)?	No ☐ Yes ☐ If no, please specify how often: Never without medication: _____
Do you have any anomalies during your period?	No ☐ Yes ☐ If no, please specify: ☐ very long ☐ very strong ☐very painful
When was your last period?	_____ /cycle length: _____ days
Did you use contraception?	No ☐ Yes ☐ If yes, please specify: ☐ pills ☐ intrauterine device from: _____ to: _____
How often do you have sexual intercourse with your partner?	approx. _____ times / week approx. _____ times / month
Have you had any operations before?	No ☐ Yes ☐ If yes, please specify:
Do you regularly take any medication?	No ☐ Yes ☐ If yes, please specify:
Has the patency of the fallopian tubes been checked?	No ☐ Yes ☐ If yes, please specify when:
Which method was used to check the patency of your fallopian tubes?	☐ Ultrasound ☐ X-ray contrast medium ☐ Laparoscopy

What was the result of your fallopian tubes patency check?	left fallopian tube: ☐ open ☐ closed right fallopian tube: ☐ open ☐ closed
Do you have any of following diseases?	☐ diabetes ☐ epilepsy ☐ asthma, chronic bronchitis ☐ diseases of the stomach/intestines ☐ kidney diseases ☐ thrombosis tendency ☐ tendency to bleed ☐ liver disease ☐ disease of the cardiovascular system ☐ headaches/migraines ☐ other: _____
Have you had contact with someone who has HIV or hepatitis?	No ☐ Yes ☐ If yes, please specify when:
Does your family have a history of any of the following?	☐ miscarriages ☐ premature births/stillbirths ☐ early death of children from natural causes ☐ physical and/or mental disabilities ☐ cystic fibrosis ☐ other: _____ ☐ Cancer diseases If yes, please specify by whom and what kind of cancer:
When was your last cervical cancer screening?	
Have you already been under medical care because of infertility?	No ☐ Yes ☐ If yes, please specify which treatments were carried out: ☐ Stimulation with tablets (clomiphene) ☐ Stimulation with injections ☐ Insemination ☐ IVF treatments ☐ ICSI treatments ☐ Cryotransfer Other: _____
Have any complications occurred after your previous IVF/ICSI treatments?	No ☐ Yes ☐ If yes, please specify: ☐ hyperstimulation ☐ bleeding ☐ infections Other: _____