Kinderwunschzentrum an der Gedächtniskirche, Dr. med. Matthias Bloechle und Dr. med. Silke Marr,
Rankestr. 34, 10789 Berlin

FB Medical history form

Please fill out this document as completely and legibly as possible.

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:
Have you already had a semen examination (spermiogram)?	No ☐ Yes ☐ If yes, please specify when:
Do you suffer from any of the following?	☐ chronic diseases ☐ metabolic diseases ☐ hormonal disorders ☐ genetic disorders If yes, please specify: ☐ other: _____
Have you had any operations before?	No ☐ Yes ☐ If yes, please specify:
Have you had a testicular injury?	No ☐ Yes ☐ If yes, please specify what kind of and when:
Did you have undescended testicles as a child?	No ☐ Yes ☐ If yes, please specify which therapy was carried out: ☐ none ☐ hormone therapy ☐ operations
Have you had any testicles infections?	No ☐ Yes ☐ If yes, please specify when:

Do you have or have you had varicose veins on your testicles (varicocele)?	No ☐ Yes ☐ If yes, please specify if it was treated: No ☐ Yes ☐
Do you regularly take any medication?	No ☐ Yes ☐ If yes, please specify:
Are you aware of the following abnormalities in your family?	☐ 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:
Have you had contact with someone who has HIV or hepatitis?	No ☐ Yes ☐ If yes, please specify when: