KINDERWUNSCH BODENSEE
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Anamneses

(Medical history)

Please complete the following sheet and send it back to the address which is written down on the right site.

Important: Please bring your vaccination card and your blood group pass, if it exists.

Information to woman:

How did you get our attention?	gynecologist / web / newspaper / friends / __________
Lastname, firstname:	
Date of birth:	
Size and weight:	______ m / ______ kg
Since when do you have desire for a child?	
Pregnancy until now / birth therefrom / abortion therefrom	/ /
Pregnancy of equal partnership?	yes ☐ no ☐
Are you married?	no ☐ yes, since:
Is your cycle constantly (26 till 35 days with a bleeding of 3 – 5 days)?	yes ☐ no ☐ but: every _____ month never without medicine ☐
Special features for bleeding:	very long ☐ very strong ☐ very painfull ☐
Last period: / How many days does your cycle have:	/ days of cycle:
Did you prevent?	with pill: no ☐ yes ☐ with loop: no ☐ yes ☐ from: till:
Smoking:	no ☐ yes ☐ if yes, how much:
Is the tubal patency checked:	no ☐ yes ☐ when:
By what method:	ultrasonics ☐ radiocontrast agent ☐ laparoscopy ☐
Result:	Left fallopian tube: open ☐ closed ☐ Right fallopian tube: open ☐ closed ☐
Hereditary deseases:	☐ diabetes ☐ epilepsy ☐ asthma, chronic bronchitis ☐ gastrointestinal disorders ☐ adrenal gland disease ☐ thrombophilia ☐ bleeding tendency ☐ liver disease ☐ disease of the cardiovascular system

	☐ headache ☐ migraine ☐ others:________________________________
Thyroid disease	no ☐ yes ☐, what kind of:
Do you have some diseases caused by prions (for example Creutzfeldt-Jacob-disease)?	no ☐ yes ☐
Did you get in contact with HIV or Hepatitis:	no ☐ yes ☐
Have you been on a long-distance trip within the last six months?	no ☐ yes ☐, in:
Previous operations:	no ☐ yes ☐, which:
Are you taking regular medications?	no ☐ yes ☐, which
Do you have allergies?	no ☐ yes ☐, which:
Do you have allergies to antibiotics?	no ☐ yes ☐, to what kind of:
Are in your family any of the following abnormalities known? (mother, father, sister, nephew, aunt, uncle)	☐ abortion ☐ premature births / stillbirths ☐ children died early ☐ physical and mental disabilities ☐ cystic fibroses ☐ other abnormalities:
In your family are cancers known?	no ☐ yes ☐, in whom and what:
Have you been because of your desire for a child in a doctor´s care before?	no ☐ yes ☐, if yes, what kind of therapy was done? stimulation with tablets (Clomifen): yes ☐ no ☐ stimulation with injection: insemination: yes ☐ no ☐ IVF ICSI: yes ☐ no ☐ Kryo: others:___________________________ yes ☐ no ☐
Complications during IVF-treatment?	no ☐ yes ☐, which: ☐ hyperstimulation of the ovaries ☐ bleedings ☐ infections ☐ others:________________________________
Time last cancer screening:	
Desired report of findings to the gynecologist?	no ☐ yes ☐
Name and address of gynecologist:	

Information to man

Lastname, firstname:	
Date of birth:	
Size and weight:	______ m / ______ kg
Do you still have children:	no ☐ yes ☐ if yes, from this relationship? no ☐ yes ☐
Smoking:	no ☐ yes ☐ if yes, how much?
Is a sperm count done?	no ☐ yes ☐ if yes, what´s the result? ☐ normal findings ☐ abnormal result
Do you suffer from chronic diseases, metabolic or hormone disorders?	no ☐ yes ☐, which:
Other diseases or surgery?	no ☐ yes ☐, which:
Did you have a testicular injury?	no ☐ yes ☐, when:
Did you have undescended testicles as a child?	no ☐ yes ☐, what kind of therapy was done? ☐ none ☐ hormone therapie ☐ surgery
Did you have an orchits?	no ☐ yes ☐, when:
Did you or do you have varicose veins on testicles?	no ☐ yes ☐, did you have a surgery because of that? no ☐ yes ☐, when:
Are you taking regular medications?	no ☐ yes ☐, which:
Are in your family any of the following abnormalities known? (mother, father, sister, nephew, aunt, uncle)	☐ abortion ☐ premature births / stillbirths ☐ children died early ☐ physical and mental disabilities ☐ cystic fibroses ☐ other abnormalities:
In your family are cancers known?	no ☐ yes ☐, in whom and what:
Have you been because of your desire for a child in a doctor´s care before?	no ☐ yes ☐, if yes, what kind of treatment have been done? ______________________________
Did you get in contact with HIV or Hepatitis:	no ☐ yes ☐
Do you have some diseases caused by prions (for example Creutzfeldt-Jacob-disease)?	no ☐ yes ☐

Authorization for Release of Medical Records, Woman

I,

miss	
born at	
resident in	

release herewith of medical records towards

☐ health insurence ____

☐ insurence ____

☐ family doctor ____

☐ gynecologist _______________________________

☐ partner miss / mister ___________________________________

☐ ____

and comply, that my medical records could transmit to the above-named institution for the purpose of

☐ my subsequent treatment

☐ someone´s information / handling

☐ ________________________

In part of a subsequent treatment I comply, that further information could be given because of a requirement from the above-named doctor.

I know, that I can cancel this authorization with a positive effect for the future.

______________________________ ____

Place, date Signature patient

Authorization for Release of Medical Records, Man

I,

mister	
born at	
resident in	

release herewith of medical records towards

☐ health insurence ____

☐ insurence ____

☐ family doctor ____

☐ gynecologist ______________________________

☐ partner miss / mister ___________________________________

☐ ____

and comply, that my medical records could transmit to the above-named institution for the purpose of

☐ my subsequent treatment

☐ someone´s information / handling

☐ ________________________

In part of a subsequent treatment I comply, that further information could be given because of a requirement from the above-named doctor.

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______________________________ ____

Place, date Signature patient