KinderwunschBodensee
Ihr Kinderwunschzentrum in Singen

registration form – woman

Last name:		**First names:**	
date of birth:			
street, house number:			
postal code, place of residende:			
profession:			
telephone private:		**Number mobile phone:**	
telephone officale:			
E-Mail private:			

Marital status:

☐ married

☐ registered civil partnership with (last name, first name partner, date of birth):

☐ single ☐ divorced ☐ widowed

Krankenversicherung:

☐ statutory health insurance

☐ privately insured in **Germany**
Name of insurance company:

☐ health insurance **abroad**

gynaecologist:

name:

address:

Do you agree that we inform your doctor about our findings? ☐ yes ☐ no

How did you find out about us?

☐ gynaecologist ☐ online
☐ newspaper ☐ friends
☐

medical history– woman

GENERAL MEDICAL HISTORY:

Size:	m	**Weight:**	kg

Do you smoke?	☐ no ☐ yes – how much:
Are you suffer from any of the following diseases?	☐ no ☐ diabetes ☐ epilepsy ☐ asthma, chronic bronchitis ☐ gastrointestinal disorders ☐ adrenal gland disease ☐ thrombophilia ☐ bleeding tendency ☐ liver disease ☐ disease of the cardiovascular system ☐ migraine ☐ others:
Do you have a disorder?	☐ no ☐ yes – following:
Do you have some diseases caused by prions? (f. e. Creutzfeldt-Jacob-disease)	☐ no ☐ yes
Did you get in contact with HIV, Hepatitis, Ebola or Zika-Virus?	☐ no ☐ yes
Have you been on a long-distance trip within the last six months?	☐ no ☐ yes – in:
Did you have operations?	☐ no ☐ yes – following:
Do you take medication regulary?	☐ no ☐ yes – following:
Do you have allergies?	☐ no ☐ yes – following:
Do you have allergies to antibiotics?	☐ no ☐ yes – following:

FAMILY HISTORY:

Was a family member affected by one of the following condition? **If yes: who?** (mother, father, sister, nephew, aunt, uncle)	☐ no abnormalities ☐ abortion ☐ premature births / stillbirths ☐ children died early ☐ physical and mental disabilities ☐ cystic fibroses ☐ other abnormalities:
Has cancer occired in your family?	☐ no ☐ yes – in whom and which:

GYNECOLOGICAL HISTORY:

Since when are you trying to conceive?				
Have you ever been pregnant?	☐ no		☐ yes – how often:	
If yes,	birth in:		miscarrige in:	
Pregnancy of equal partnership?	☐ yes		☐ no	
Is your cycle regular? (26 till 35 days with a bleeding of 3–5 days)	☐ yes		☐ no	
	but: every		month	
	☐ never without medicine			
Do you see following bleeding abnormalities?	☐ very long	☐ very strong	☐ very painfull	
When did your last period start?		days of cycle		days
When did you have the last cancer screening?				
Did you been using contraception?	with contraceptive:	☐ yes	☐ no	
	with loop:	☐ yes	☐ no	
	from:		till:	
How often do you have sexual intercourse with your partner?	about		time/week	
	about		time/month	
Is the tubal patency checked?	☐ no	☐ yes – when:		
By what method?	☐ ultrasonics	☐ radiocontrast agent	☐ laparoscopy	
Result?	Right fallopian tube:	☐ open	☐ close	
	Left fallopian tube:	☐ open	☐ close	

PRE-TREATMENT:

Have you already sought counselling for infertility?	☐ no	☐ yes	
What treatment was performed?	stimulation with tablets:	☐ yes	☐ no
	stimulation with injections:	☐ yes	☐ no
	insemination:	☐ yes	☐ no
	IVF:	☐ yes	☐ no
	ICSI:	☐ yes	☐ no
	Thawing cycle:	☐ yes	☐ no
	others:		
Complications during fertility treatment?	☐ no	☐ yes – which:	
	☐ hyperstimulation of the ovaries		
	☐ bleedings		
	☐ infections		
	☐ others:		

registration form – man

Last name:		**First name:**	
date of birth:			
street, house number:			
postal code, place of residende:			
profession:			
telephone private:		**Number mobile phone:**	
telephone officale:			
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Marital status:

☐ married

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Krankenversicherung:

☐ statutory health insurance

☐ privately insured in **Germany**
Name of insurance company:

☐ health insurance in **abroad**

urologist:

name:

address:

Medical history – man

GENERAL MEDICAL HISTORY:

Size:		M	**weight:**		kg

Do you already have children:	☐ no	☐ yes - from this relationship?	☐ no	☐ yes
Smoking?	☐ no	☐ yes – how much per day:		
Do you suffer from diseases, metabolic or hormone disorders?	☐ no	☐ yes – following:		
Do you have some diseases caused by prions? (e. g. Creutzfeldt-Jacob-disease)	☐ no	☐ yes		
Did you get in contact with HIV, Hepatitis, Ebola or Zika-Virus?	☐ no	☐ yes		
Have you been on a long-distance trip within the last six months?	☐ no	☐ yes – in:		
Do you have surgery?	☐ no	☐ yes – following:		
Do you take medication regulary?	☐ no	☐ yes – which:		

FAMILY HISTORY:

Was a family member affected by one of the following condition? **If yes: who?** (mother, father, sister, nephew, aunt, uncle)	☐ no abnormalities ☐ abortion ☐ premature births / stillbirths ☐ children died early ☐ physical and mental disabilities ☐ cystic fibroses ☐ other abnormalities:
Has cancer occired in your family?	☐ no ☐ yes – in whom and what:

UROLOGICAL HISTORY:

Was a sperm count performed?	☐ no	☐ yes – what´s the result:	☐ normal findings ☐ abnormal result
Did you have a urogenital 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 your testicles?	☐ no	☐ yes	Did you have a surgery because of that? ☐ no ☐ yes – when:

PRE-TREATMENT:

Have you already sought counselling for infertility?	☐ no	☐ yes – following: