MEDICAL HISTORY - MALE

Date: ______________________

kinderwunschzentrum
STUTTGART
PRAXIS VILLA HAAG
DR. MED. D.B. MAYER-EICHBERGER

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 ☐ no ☐

Do you smoke? yes ☐ if yes, what and how many a day: ______________________ no ☐

Do you drink alcohol? never ☐ rarely ☐ sometimes ☐ frequent ☐

Your treating family doctor: ______________________

Your treating urologist: ______________________

Are you healthy: yes ☐ no ☐

If no, which illness do you have? ______________________

Remarks: ______________________

☐ Diabetes	☐ Thrombosis	☐ Asthma
☐ Epilepsy	☐ Thyroid dysfunction	☐ Gastro-intestinal disease
☐ Cardiovascular disease	☐ 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 ☐

Did you already have a test for mucoviscidosis / cystic fibrosis before? yes ☐ no ☐

Result: ______________________

Did you already have a genetic counseling or chromosomal analysis before? yes ☐ no ☐

Result: ______________________

Did you already have operations? yes ☐ no ☐

If yes, which ones and when: ______________________

Last name:	First name:

Do you know of any allergies you have: 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 ☐

Did you suffer from mumps as a child? no ☐ yes ☐

Have there been previous pregnancies? no ☐ yes ☐

with a different partner? no ☐ yes ☐

If yes, result of the pregnancy: ______________________________

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 ☐

Have there been any of the following chronic diseases in your family,

e.g. siblings, parents or grandparents? no ☐ yes ☐

Cancer/other tumors ______________________________

Genetic diseases ______________________________

Cardiac or circulatory troubles ______________________________

Others ______________________________

Last name:	First name:

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 blood count, 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 if 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