Fertility Center Berlin

Dr. med. A. Tandler-Schneider
Dr. med. A. Siemann
I. von Plauen
Dr. med. M. Krause
und Kolleg:innen
Spandauer Damm 130, 14050 Berlin
Tel: 030 / 2332081-10
E-Mail: info@fertilitycenterberlin.de

Partner Survey

ID: _____

Please fill out the survey as completely as possible and in a legible form.

First Name _____	Last Name _____
Country of origin _____	Occupation _____
Family status _____	Date of Birth _____

Desire to Have Children and Physical Characteristics:

Have been trying to conceive for	_____ Months	☐ not yet
Intended family size	_____	
Height and Weight	_____ cm	_____ kg
Smoking ☐ no	☐ Yes, about ____cigarettes per day	
Alcohol ☐ no	☐ sometimes	☐ regularly
Drugs ☐ no	☐ if yes, which ones: _____	

Medication

Medications taken regularly or currently
_____
_____
_____

Dr. med. A. Tandler-Schneider
Dr. med. A. Siemann
I. von Plauen
Dr. med. M. Krause
und Kolleg:innen
Spandauer Damm 130, 14050 Berlin
Tel: 030 / 2332081-10
E-Mail: info@fertilitycenterberlin.de

Medical History

Previous operations
Pre-existing diseases / Allergies
Mental or neurological disorders
Infectious diseases, including sexually transmitted diseases
Trips outside Europe in the past 12 months

Fertility and Treatments

Have you had any semen analysis? If yes, please bring them with you. ☐ yes ☐ no
Have you ever conceived a pregnancy with a previous sexual partner? ☐ yes ☐ no
Previous fertility treatments
Urological Disorders
What else would you like to tell us about yourself?

I hereby confirm that all the information I have provided is complete and truthful to the best of my knowledge and belief.

Berlin, _____ _____

Partner's Signature

Ausgedruckt unterliegt das Dokument nicht dem Änderungsdienst