

Formulare **Medical History Form - Patient**

Patient Survey

ID: _____

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

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: _____	
folic acid intake	☐ yes ☐ no	

Medication

Medications taken regularly or currently

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Medical History

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

Gynecological History

Menstrual cycle length	_____ Days
Pain during your period	
☐ yes	☐ no
Name of your gynecologist	_____
Last check-up	on _____
Pregnancies – please specify the year and outcome, e.g., birth, miscarriage, curettage, or tubal pregnancy	
Previous fertility treatments	
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, _____

Patient's Signature