Anamnese Frau englisch

Kinderwunschzentrum Dresden
Prager Str. 8a
01069 Dresden
Telefon: +49 (0) 351 5014000
Telefax: +49 (0) 351 50140028
www.ivf-dresden.de

Medical history

Please fill in this form as completely as possible in printed font!
Important: please bring your vaccination certificate, recent medical findings and current cancer screening to your appointment!

Information provided by the woman

Where did you hear about us?	Gynaecologist / online / newspaper / friends / _____
Name, first name, birth name if applicable:	
Date of birth / place of birth:	
Occupation:	
E-mail address:	
Height and weight:	_____,_____ m / _____ kg
Since when are you trying to become pregnant?	
Previous pregnancies / births / miscarriages:	_____ / _____ / _____
Pregnancies within current partnership?	☐ No ☐ Yes
Are you married with your current partner?	☐ Yes, since: _____ ☐ No ☐ No, married to former partner
Is your menstrual cycle regular? (every 26-35 days with the bleeding 3-5 days)	☐ Yes ☐ No, every _____ months
Peculiarities of your menstruation:	☐ Very long ☐ Very strong ☐ Very painful
Date of your last menstruation:	_____ / length of the cycle: _____ days
Did you ever use contraception before?	☐ No ☐ Yes, contraceptive pill ☐ Yes, IUD from _____ until _____

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How often do you have sex with your partner?	~ _____ times / week ~ _____ times / month
Are you smoking?	☐ No ☐ Yes, _____ per day
Has the patency of the fallopian tubes been checked? Results:	☐ No ☐ Yes, date: _____ ☐ Ultrasound with contrast agend ☐ Laparoscopy Left tube ☐ Open ☐ Closed Right tube ☐ Open ☐ Closed
Pre-existing conditions:	☐ Diabetes ☐ Epilepsy ☐ Asthma, chronic bronchitis ☐ Disease of stomach and intestines ☐ Kidney / renal disease ☐ Thrombosis ☐ Bleeding disorder ☐ Liver disease ☐ Disease of the cardiovascular / vascular system ☐ Headache ☐ Migraine ☐ Other: _____
Is there a thyroid disease?	☐ No ☐ Yes, please specify _____
Previous operations	☐ No ☐ Yes, please specify _____
Regular medications:	☐ No ☐ Yes, please specify _____
Known allergies?	☐ No ☐ Yes, please specify _____
Do have any allergies against antibiotics?	☐ No ☐ Yes, please specify _____

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Are any of the following anomalies known in your family? (mother, father, siblings, nephews, aunts, uncles)	☐ Miscarriages ☐ Premature births / stillbirths ☐ Sudden infant death ☐ Physical and/or mental disabilities ☐ Cystic fibrosis ☐ Other: _____
Is there a history of cancer in your family?	☐ No ☐ Yes, please specify the family member and type of cancer:
Have you already had any kind of fertility treatment?	☐ No ☐ Yes, please specify the kind of treatment: ☐ Stimulation ☐ Yes ☐ No ☐ Insemination ☐ Yes ☐ No ☐ IVF (punctures) ☐ Yes ☐ No ☐ ICSI ☐ Yes ☐ No ☐ Cryotransfer ☐ Yes ☐ No ☐ Other ☐ Yes ☐ No
Did experience any complications during the previous treatments?	☐ No ☐ Yes, please specify ☐ Overstimulation ☐ Bleedings ☐ Infections ☐ Other:_____
Date of your last cancer screening:	
Would you like us to send a medical report to you gynaecologist?	☐ No ☐ Yes, please write down the name and address:

Place, date Signature

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Registration for woman

Name, first name:	**Profession:**
Date and place of birth:	**Mobile phone number:**
Country, zip code, city	**Street, house number:**
E-mail address:	
Treating gynaecologist: name and address	
Report to your treating gynaecologist?	☐ Yes ☐ No
Marital status	☐ married to treatment partner ☐ single ☐ divorced ☐ married otherwise
Health insurance:	☐ statutory health insurance (German GKV) ☐ private health insurance

Declaration (in case of private health insurance or foreign health insurance):

The claim for reimbursement is directed directly against the treated person and is independent of a possible reimbursement. I am aware that, as a private patient, I am fully liable for payment myself. I undertake to pay the invoice upon receipt without deduction. The billing will be done according to the valid rates according to the current version of the GOÄ of 09.02.1996 and will be invoiced at 2.3 times the fee rate. In addition, individual services can generally be charged at 3.5 times the fee rate. If both partners participate in a consultation for infertility treatment, each partner will be billed separately. Certain external services (like laboratory examinations, tissue samples or radiological examinations) may be necessary for the treatment that are not provided by the "Kinderwunschzentrum Dresden".

Consent to unencrypted e-mail communication

I hereby give my consent to unencrypted e-mail communication with the "Kinderwunschzentrum Dresden" to send me reports and medical letters, in this respect I release the staff at the "Kinderwunschzentrum Dresden" from confidentiality. I assure that I either have sole access to the above-mentioned e-mail box or that I consent to other persons that have access, to view my communication with the "Kinderwunschzentrum Dresden".

I agree: ☐ **I do not agree:** ☐

Obligation of confidentiality and data protection (DSGVO/ GDPR)

To treat you and your partner at the "Kinderwunschzentrum Dresden", it is necessary that we discuss the findings with you and your partner and to inform you about treatments and the resulting consequences, appointments and other information. For this purpose, it is absolutely necessary that you release each other (you and your partner) from the obligation of confidentiality. Also, we recommend to release your external physicians from the obligation of confidentiality towards us, so that we can exchange necessary information and treatment data with our colleagues. I hereby release the physicians and medical assistants of the "Kinderwunschzentrum Dresden" from the medical confidentiality towards my partner as well as my external physicians. Furthermore, I confirm that the patient information on data protection (privacy notice) is available for inspection in the practice and that I have been able to ask questions about it in the practice.

I declare my consent that my patient data will be collected and processed at the "Kinderwunschzentrum Dresden". I declare my consent that the "Kinderwunschzentrum Dresden" may request treatment data and findings concerning me from other physicians and service providers for the purpose of documentation and further treatment.

I declare my consent that treatment data and findings concerning me may be transmitted to other doctors and service providers treating me. This also includes, for example, external laboratories that are providing special analyses (such as blood values) that are necessary for my treatment.

I am aware that I can revoke this declaration in whole or in part at any time in the future.

_____ _____

Place, date Patient's signutaure