Personal information for single women wishing to conceive

General information

First and last name ..... Date of birth .....

Street address ..... Profession .....

Postal code and city .....

E-Mail .....

Telephone (day time) .....

Our questions for you

Your height .....

Your weight .....

Period / monthly cycle ☐ regular: Every ..... days and lasts ..... days ☐ irregular

How long have you been trying to conceive? (in years) .....

Have you already undergone fertility treatment? ☐ Yes ☐ No

Where, when and how? .....

Former pregnancies? ☐ Yes ☐ No

Please provide year: Births ..... Ectopic pregnancies ..... Miscarriages ..... Terminations .....

Do you have any allergies? ☐ Yes ☐ No

List allergies here .....

Do you take medication? ☐ Yes ☐ No

Please provide the exact name, strength and dosage .....

Do you suffer from a serious illness? ☐ Yes ☐ No

List illness(es) here .....

Have you had an important operation in the past? ☐ Yes ☐ No

Type of operation & year .....

Has the patency of the fallopian tubes been tested? ☐ Yes ☐ No

When and what was the result? .....

Have you undergone a sterilisation procedure? ☐ Yes ☐ No When? .....

Do you have sufficient vaccine protection (twice) against measles and rubella? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many cigarettes per day? .....

May we inform your doctor of your treatment reports in writing? ☐ Yes ☐ No

How did you hear about us? ☐ Acquaintances ☐ Book ☐ Internet ☐ Newspaper ☐ Other doctor ☐ Podcast

☐ Radio advertising ☐ Social Media ☐ Other: .....

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