FB Ki39 Medical History HIM

Surname _____

First name _____

Birthdate _____

Birthname _____

Address:
Street, house number:

_____
ZIP Code, city:

_____

Phone (landline) _____

Mobile _____

Responsible health insurance: _____

Responsible Health Clinic: ☐ Vilseck ☐Hohenfels

☐Grafenwöhr

E-mail _____

Nationality_____

Regular occupation _____

Married ☐ yes ☐ no

Bodyweight: _____kg / llbs

Height: _____ cm / ft-in

Partners name + birthdate:

_____

Have you ever had a urological examination?

☐ yes ☐ no

If so, when? _____ (year)

Have you been diagnosed with varicoceles or an infection of the seminal ducts?

☐ yes ☐ no

Do you take any medications? ☐ yes ☐ no

If so, which ones? _____

_____

Do you smoke?

☐ yes ☐ no

If yes:

☐ 1-5 cigarettes/day ☐ 5-15 cigarettes/day

☐ more than 15 cigarettes/day

How long have you been smoking?

about _____ years

Do you already have children

☐ yes ☐ no

If so, how many? _____

Birthyears of your children:_____

Have you ever had an operation?

☐ yes ☐ no

If so, what kind of operation and when?

_____

_____ (year)

Do you often talk to your partner about the wish of having a child?

☐ often ☐ sometimes ☐ never

Do you talk to friends or family about your wish of having a child?

☐ often ☐ sometimes ☐ never

Dear patient,

please take your ID-Card with you to every appointment in our doctors office.

We will inform you about the costs of the therapie. If there are any questions please ask us.

_____

(Patient signature)

_____

(Place and date)