

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 / lbs

Height: _____ cm / ft-in

Partners name & birthdate:

Are you aware of any pre-existing medical conditions?

If so, which ones? _____

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 a surgery?

☐ yes ☐ no

If so, what kind of surgery 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)

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