

Dear Patient,

The personal consultation is important and is not intended to be replaced by this form, but instead be facilitated in terms of time. All information provided is subject to doctor-patient confidentiality, which also applies to all information provided in this questionnaire. Please help us by filling it out carefully.

Name:	First name:
Date of birth:	Profession:
Address: (street, house number, postcode and town)	
Tel. no. home: Tel. no. mobile: email:	Insurance: Referring gynaecologist:

First day of last period (date)	Regular cycle no <input type="radio"/> yes <input type="radio"/> Abnormal bleeding yes <input type="radio"/> no <input type="radio"/>
Cycle duration (days from period to period): Period duration (days of bleeding):	Ovulation trigger? yes <input type="radio"/> no <input type="radio"/> (was ovulation triggered by medication)
Anomalies during the current pregnancy and any in-patient stays? no <input type="radio"/> yes <input type="radio"/> , details:	Preliminary examinations and results (please mark with a cross)
	Nuchal fold scan (O +biochemical test) yes <input type="radio"/> no <input type="radio"/> Unremarkable yes <input type="radio"/> no <input type="radio"/>
	NIPT - genetic blood test (VeracityTEST, PraenaTest, HarmonyTest, FetalisTest) yes <input type="radio"/> no <input type="radio"/> Unremarkable yes <input type="radio"/> no <input type="radio"/>
	Procedures (amniocentesis / CVS) yes <input type="radio"/> no <input type="radio"/> Unremarkable yes <input type="radio"/> no <input type="radio"/>
	Malformation ultrasound yes <input type="radio"/> no <input type="radio"/> Unremarkable yes <input type="radio"/> no <input type="radio"/>

Has **artificial insemination** taken place? _____ yes no
 If yes: which method? _____ Please specify day of puncture: _____
 Cryopreservation? _____ yes no
 if yes: Date of freezing: _____ Transfer: _____ Number: _____

Size:	Nicotine yes <input type="radio"/> no <input type="radio"/> number of cigarettes: _____ no <input type="radio"/>
Current weight:	Alcohol yes <input type="radio"/> no <input type="radio"/> Amount: _____ no <input type="radio"/>
Are you and your partner related? no <input type="radio"/> yes <input type="radio"/> (e.g. cousins)	Other infections? yes <input type="radio"/> no <input type="radio"/> with: _____ no <input type="radio"/> Is there an infection with Hepatitis A/B/C? yes <input type="radio"/> no <input type="radio"/>

Allergies: no <input type="radio"/> yes <input type="radio"/> , details:	Current medication (preparation / dose) no <input type="radio"/> yes <input type="radio"/> Others:
	ASA or Heparin (blood thinning) yes <input type="radio"/> no <input type="radio"/> Folic acid? yes <input type="radio"/> no <input type="radio"/>

Births: no <input type="radio"/> yes <input type="radio"/> , details: (in each case year / gender / birth weight / type of delivery)	Anomalies with previous pregnancy / birth no <input type="radio"/> yes <input type="radio"/> , details,
	Miscarriages: no <input type="radio"/> yes <input type="radio"/> , details (year, week of pregnancy):
Ectopic pregnanc: no <input type="radio"/> yes <input type="radio"/> (year)	Termination: no <input type="radio"/> yes <input type="radio"/> , details (year)

Other conditions: no <input type="radio"/> yes <input type="radio"/> , details (diabetes, high blood pressure, thrombosis, cancer etc.)	Conditions in the family: no <input type="radio"/> yes <input type="radio"/> , details (including the child's father's family) (hereditary disorders, heart conditions since birth etc.)
Gynaecological and other operations: no <input type="radio"/> yes <input type="radio"/> , details (year / type)	