



Give your fertility a future.

Our "fertility for future" initiative is designed to enable young people to take self-determined fertility precautions and thereby make it possible to plan a family. We are very pleased that you are already consciously thinking about your future family planning and are interested in our "FertiCheck".

For the "FertiCheck" you will receive a checklist from us with all the required findings and examinations. After all medical results are available, you will discuss them in a personal consultation with our team of doctors and receive individual recommendations for your fertility care.

Personal data	Female	Partner
Academic title		
First name		
Last name		
Maiden name		
Date of birth		
Place of birth		
Social security number (10 digits)		
Insurance institution		
Supplementary insurance		
Marital status	<input type="radio"/> married	<input type="radio"/> civil partners <input type="radio"/> in cohabitation
Citizenship		
Profession, Zip code work		
Address		
Zip code and city		
Country		
Telephone number		
Gynaecologist / Urologist (Name + Zip code, city)		
Additional information		
Preferred communication language	<input type="radio"/> German	<input type="radio"/> English <input type="radio"/> Serbo-Croatian <input type="radio"/> Italian <input type="radio"/> Turkish <input type="radio"/> Arabic <input type="radio"/> Other:
We are willing to talk about our situation...	<input type="radio"/> ...personally & publicly (for example TV). <input type="radio"/> ...anonymously.	
How did you find out about the Kinderwunschzentrum an der Wien?	Gynaecologist / Urologist:	<input type="radio"/> referred us directly <input type="radio"/> suggested a few clinics
	Online:	<input type="radio"/> "fertility for future" Website <input type="radio"/> Google search <input type="radio"/> Social media (Facebook, Instagram, YouTube) <input type="radio"/> Internet forum
		<input type="radio"/> Recommended by family / friends / colleagues
		<input type="radio"/> Institute / other person:



Checklist of necessary examinations

Request your laboratory referral for the blood test easily and conveniently online:

<https://www.kinderwunschzentrum.at/en/referral> or scan our QR-code →



FertiCheck for the female partner - 3 examinations:

One blood test between the 1st and 4th day of your menstrual bleeding:

Hormone status:	FSH LH E2 prolactin testosterone progesterone TSH TPO antibodies AMH
Vitamins:	25-OH-Vitamin D
Antibody testing:	rubella IgG antibodies (specific value, no ratio) VZV varicella IgG antibodies (chickenpox)
Blood coagulation:	APC-resistance (this test has no expiration date)

One examination at your gynaecologist:

Smear tests:	vaginal secretion & bacterial culture cervical chlamydia smear
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Examination of the fallopian tubes (patency and function):

X-Ray (HSG):	possible in any X-ray institute
<u>or</u>	
Ultrasound (HyCoSy):	possible at our center or selected gynecologists

FertiCheck for the male partner - 1 examination:

A spermogram according to WHO criteria 2010

This analysis is conducted directly in our IVF-laboratory in our center - short-term appointments available!

All done?

Please keep in mind that your test results should not be older than 6 months!
Send us your test results approximately 10 days before your consultation via e-mail:
start@kinderwunschzentrum.at

We are here for you. You can contact us during our telephone hours under T +43 1 934 69 79.

Mon - Thu: 8 am - 12 pm | 1 pm - 4 pm Fri: 8 am - 1 am



www.fertilityforfuture.at | www.kinderwunschzentrum.at/en



www.facebook.com/kinderwunschzentrum.an.der.wien



www.instagram.com/ivfwien



www.youtube.com/ivfwien





Female questionnaire

Filling out this questionnaire is very important for your „FertiCheck“. Take a few minutes and fill it out completely and conscientiously. This will enable us to provide you with the best possible care and give you individual recommendations for your fertility care in a personal consultation!

* Important: Please submit your medical findings for all questions marked with this icon!

Fertility & menstrual cycle

Menstrual cycle duration (from the first day of one period until the first day of the next period)	Duration in days:			
	<input type="radio"/> regular	<input type="radio"/> irregular	<input type="radio"/> intermenstrual bleeding	
Menstruation	My first ever menstruation occurred by the age of:			
	The first day of my last menstruation was on:			
	<input type="radio"/> I have not had my menstruation for a long time.			
	<input type="radio"/> The cramps are very painful and I have to take pain relievers regularly.			
Menopause of my mother	<input type="radio"/> < 45 years	<input type="radio"/> 45 - 50 years	<input type="radio"/> 51 - 55 years	<input type="radio"/> > 55 years
Your pregnancies	Spontaneous delivery:	Year:		
	Caesarean section:	Year:		
	Miscarriage:	Year:		
	Tubal pregnancy:	Year:		
	Abortion:	Year:		
Pregnancies - notes: (e.g. multiple births, reason for c-section, premature birth, stillbirth, etc.)				
Have you ever taken any medication for ovarian stimulation in order to achieve pregnancy? (e.g. Clomiphen, Femara, etc.)	Name of the medication		Since when & how long?	
Fallopian tubes examination *	<input type="radio"/> Yes, most recently (year):		<input type="radio"/> No	
	<input type="radio"/> X-Ray (HSG)	<input type="radio"/> HyCoSy	<input type="radio"/> Laparoscopy (LSK)	

Medication

Regular medication	Name & Dosage	Since when & how long?
Acne treatment current/past (with Vitamin-A-Acid, e.g. Isotretinoin)		
Medication allergy (e.g. antibiotics, Aspirin, pain relievers, etc.)		



Gynaecological & infectious diseases

	When?	Notes		
Endometriosis *				
Ovarian cysts				
Ovarian inflammation				
Uterus malformation *				
PCO syndrome *				
Hepatitis B or C		<input type="radio"/> elapsed	<input type="radio"/> acute	<input type="radio"/> chronic
		treated with:		
HIV		treated with:		
Syphilis		treated with:		
Chlamydia infection		treated with:		

Other diseases & surgeries

	Which one?	Notes
Other diseases (e.g. epilepsy, blood-clotting disorder, cardiac arrhythmia)		
Diseases within the family (e.g. abortions, genetic diseases, cancer, etc.)		
	Year	Notes
Laparoscopy (LSK) *		
Hysteroscopy (HSK) *		
Conisation		
Curettage		
Other surgeries:		

Lifestyle

Height & weight			
Smoking	<input type="radio"/> I was never a smoker.	<input type="radio"/> I am an occasional smoker.	
	<input type="radio"/> Yes, I smoke cigarettes/day.	<input type="radio"/> I am a non-smoker since:	
Alcohol	I drink (quantity) alcoholic beverages per week.		
Sports with excessive exhaustion (e.g. marathon training, heavy weight lifting, competitive sports, etc.)	<input type="radio"/> No	<input type="radio"/> Yes, namely:	
	<input type="radio"/> I have the impression that the topic of family planning weighs on me emotionally.		



Male questionnaire

Filling out this questionnaire is very important for your „FertiCheck“. Take a few minutes and fill it out completely and conscientiously. This will enable us to provide you with the best possible care and give you individual recommendations for your fertility care in a personal consultation!

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Fertility & andrology

Achieved pregnancies	<input type="radio"/> Yes	<input type="radio"/> No		
			Notes (Diagnosis, treatment, etc.)	
Malformation of the spermatic duct	<input type="radio"/>			
Undescended testicle as a child	<input type="radio"/>			
Testicular inflammation	<input type="radio"/>			
Injury of the testicles	<input type="radio"/>			
Varicose veins in the testicles (varicocele)	<input type="radio"/>	<input type="radio"/> no surgery (yet)	<input type="radio"/> surgery in (year):	
Testicular tumor *	<input type="radio"/>	<input type="radio"/> no surgery (yet)	<input type="radio"/> surgery in (year):	
		When?	<input type="radio"/> chemo therapy	<input type="radio"/> radiation
Vasectomy	<input type="radio"/>	<input type="radio"/> not reversed	<input type="radio"/> surgically reversed in (year):	
Erectile dysfunction	<input type="radio"/>			
Difficulties with delivering sperm (e.g. in an unfamiliar environment)	<input type="radio"/>			

Medication

	Name & Dosage	Since when & why?
Regular medication		
Medication allergy (e.g. antibiotics, Aspirin, pain relievers, etc.)		

Infectious diseases

	When?	Notes		
Hepatitis B oder C		<input type="radio"/> elapsed	<input type="radio"/> acute	<input type="radio"/> chronic
		treated with:		
HIV		treated with:		
Syphilis		treated with:		
Chlamydia infection		treated with:		
Mumps		Testicles affected?	<input type="radio"/> Yes	<input type="radio"/> No



Other diseases & surgeries

	Which one?	Notes
Other diseases (e.g. epilepsy, blood-clotting disorder, cardiac arrhythmia)		
Diseases within the family (e.g. abortions, genetic diseases, cancer, etc.)		
	Year	Notes
Other surgeries:		

Lifestyle

Height & weight		
Smoking	<input type="radio"/> I was never a smoker.	<input type="radio"/> I am an occasional smoker.
	<input type="radio"/> Yes, I smoke cigarettes/day.	<input type="radio"/> I am a non-smoker since:
Alcohol	I drink (quantity) alcoholic beverages per week.	
Sports with excessive exhaustion (e.g. marathon training, heavy weight lifting, competitive sports, etc.)	<input type="radio"/> No	<input type="radio"/> Yes, namely:
Mental health	<input type="radio"/> I have the impression that the topic of family planning weighs on me emotionally.	

Legal disclaimer & signature

This document is only valid in conjunction with the consent for the General Data Protection Regulation (GDPR). Processing and saving of your personal data is not possible without this consent.

With our signatures we confirm the accuracy and completeness of our information.

Date	Signature (female)	Signature (partner)