Every journey starts with first step.

We are honored that you consider a fertility treatment at PCOS-Zentrum and that we are allowed to be your companion on your Fertility Journey! It is our wish to make your Fertility Journey as pleasant and free from worry as possible. The first important step is a personal consultation with our team of doctors. During this first meeting you will get to know us and our institute. On our checklist of necessary examinations you will find all the medical findings needed in order to conduct the first appointment and plan your treatment. During the consultation your test results will be discussed and your individual therapy concept and a plan of expected costs will be created for you. The first consultation lasts about 45 minutes, includes a 3D ultrasound examination and costs 200 €.

Personal Data	Female	Male
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	o married* o civil partners* o in cohabitation *Please bring along your marriage or civil partnership certificate to the first consultation.	
Citizenship		
Profession, Zip code work		
Address		
Zip code and city		
Country		
Telephone number		
Gynaecologist / Urologist (Name + Zip code, city)		

Additional information		
Preferred communication language	o German o English o Serbo-Croatian o Italian o Turkish o Arabic o Other:	
We are willing to talk about our situation and the treatment...	o ...personally & publicly (for example TV). o ... anonymously.	
How did you find out about the Kinderwunschzentrum an der Wien?	Gynaecologist / Urologist:	o referred us directly o suggested a few clinics
	Online:	o Google search o Social media (Facebook, Instagram, YouTube) o Internet forum
	o Recommended by family / friends / colleagues	
	o Institute / other person:	

Checklist of necessary examinations

Ideally, the medical findings listed below should already be available at your first consultation, as this is the only way to plan an individualized treatment. If the findings have not yet been compiled at the first appointment, they must be sent to us by the start of treatment at the latest.

For the female partner - 2 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

For the male partner – 1 examination:

A spermiogram according to WHO criteria 2010

Short-term appointments for the spermiogram can be arranged in our institute!

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 first consultation via e-mail:
start@kinderwunschzentrum.at | Subject: PCOS-Consultation exclusively at Dr. Pekic

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

Tip for your Fertility Journey!

Please send us all necessary findings or documents so that we can ideally prepare your first consultation and you do not lose valuable time. We thank you for your trust and look forward to starting your Fertility Journey!

www.pcos-zentrum.at

www.facebook.com/pcoszentrum

www.instagram.com/pcoszentrum

www.youtube.com/ivfwien

Female questionnaire

Filling out this questionnaire correctly and completely is very important. Through this information, we can determine the reasons for your infertility and create your individual therapy concept.

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

Fertility & menstrual cycle

Infertility	We've been trying to become pregnant since			(month and year)
Menstrual cycle duration (from the first day of one period until the first day of the next period)	Duration in days:			
	o regular	o irregular	o intermenstrual bleeding	
Menstruation	My first ever menstruation occurred by the age of:			
	The first day of my last menstruation was on:			
	o I have not had my menstruation for a long time.			
	o The cramps are very painful and I have to take pain relievers regularly.			
Menopause of my mother	o < 45 years	o 45 - 50 years	o 51 - 55 years	o > 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 *	o Yes, most recently (year):	o No		
	o X-Ray (HSG)	o HyCoSy	o Laparoscopy (LSK)	
Fertility treatments	o I have never had a fertility treatment before. o I have had a previous fertility treatment in another institute (IVF, ICSI). *			

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		o elapsed	o acute	o 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	o I was never a smoker.	o I am an occasional smoker.
	o Yes, I smoke cigarettes/day.	o 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.)	o No	o Yes, namely:
Mental health	o My unfulfilled wish of having a child is stressing me mentally and emotionally.	
	o Please send me non-committal invitations to your relaxation groups.	

Male questionnaire

Filling out this questionnaire correctly and completely is very important. Through this information, we can determine the reasons for your infertility and create your individual therapy concept.

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

Fertility & andrology

Achieved pregnancies	o none	o Yes, with current partner		o Yes, with previous partner
		Notes (Diagnosis, treatment, etc.)		
Malformation of the spermatic duct	o			
Undescended testicle as a child	o			
Testicular inflammation	o			
Injury of the testicles	o			
Varicose veins in the testicles (varicocele)	o	o no surgery (yet)	o surgery in (year):	
Testicular tumor ✱	o	o no surgery (yet)	o surgery in (year):	
		When?	o chemo therapy	o radiation therapy
Vasectomy	o	o not reversed	o surgically reversed in (year):	
Erectile disfunction	o			
Difficulties with delivering sperm (e.g. in an unfamiliar environment)	o			

Medication

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

Infectious diseases

	When?	Notes		
Hepatitis B or C		o elapsed	o acut	o chronic
		treated with:		
HIV		treated with:		
Syphilis		treated with:		
Chlamydia infection		treated with:		
Mumps		Testicles affected?	o Yes	o 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	o I was never a smoker.	o I am an occasional smoker.
	o Yes, I smoke cigarettes/day.	o 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.)	o No	o Yes, namely:
Mental health	o My unfulfilled wish of having a child is stressing me mentally and emotionally.	
	o Please send me non-committal invitations to your relaxation groups.	

Details on previous IVF/ICSI treatments

Treatment type	Amount	Year	Using donor sperm?	
In-vitro fertilization (IVF/ICSI)			O Yes	O No
Cryocycle			O Yes	O No
Egg- or embryo donation			O Yes	O No

	1st cycle	2nd cycle	3rd cycle	4th cycle
Institute (Where?)				
Stimulation medication	Please send us the stimulation protocol. You can obtain those documents from your previous institute			
Date of treatment				
Number of follicles				
Number of oocytes				
Number of fertilized oocytes				
Method of fertilization	O IVF O ICSI	O IVF O ICSI	O IVF O ICSI	O IVF O ICSI
Number of transferred embryos				
Quality of transferred embryos	Please send us the egg cell sheets. You can obtain those documents from your previous institute			
Timing of transfer	O Day 2-3 O Day 4-6	O Day 2-3 O Day 4-6	O Day 2-3 O Day 4-6	O Day 2-3 O Day 4-6
Outcome of treatment				
The following additional methods were used during one or more of the treatment cycles	O Embryoglue O Assisted hatching (AHA) O Physiological ICSI (pICSI) O Polar body biopsy O Pre-implantation diagnostic (PGD)			
Notes				

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 partner)	Signature (male partner)

Consent for the General Data Protection Regulation (GDPR)

Personal Data

PATIENT first and last name in capitals, date of birth

PARTNER first and last name in capitals, date of birth

IMPORTANT: **Please cross out all points that you do not consent to!** This consent can be revoked anytime. The legitimacy of your data processing remains unaffected until the receipt of the revocation. Please don't forget to sign this document!

Data processing and information transmission

As part of your treatment at the Kinderwunschzentrum an der Wien your personal data will be processed and saved electronically. According to paragraph 18 of Austrian reproductive law your data has to be saved for 30 years and cannot be deleted before the end of this period. If you do not consent to this we cannot offer you a treatment in our institute.

During the course of your therapy, treatment-related and personal data will be sent to you.
If your personal details change we ask you to actively transmit your new data!

We are aware that the transmission of data via unencrypted email can give third parties access to this information as well as the ability to change data. We are also aware that this can lead to knowledge of our health status. We are responsible for the truthfulness of the data as well as any transmission.

We consent to the transmission of treatment-related information (e.g. referrals, prescriptions, contracts, information newsletter, etc.) by the Kinderwunschzentrum an der Wien to the following e-mail address(es).

E-mail address patient:	
E-mail address partner:	

We consent to the transmission of treatment-related data by post. If you do not consent all documents will be issued to you exclusively in person. Please note that this can considerably delay or complicate your treatment.

Information transmission to partner

We consent to the transmission of treatment-related data to my partner.

Information transmission to attending physicians

We consent to the transmission of treatment-related data (treatment progression, treatment outcome) by the Kinderwunschzentrum an der Wien to our attending physician via post or email.

Signatures

Date	Signature patient	Signature partner