

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 1 hour and costs € 116,-.

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	<input type="radio"/> married* <input type="radio"/> civil partners* <input type="radio"/> 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	<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 and the treatment...	<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"/> 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 easily and conveniently online:

www.pcos.at/laborueberweisung or scan our QR-code →



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
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For the male partner – 1 examination:

A spermogram according to WHO criteria 2010

Short-term appointments for the spermogram 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



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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 <u>and</u> year)		
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)
Fertility treatments	<input type="radio"/> I have never had a fertility treatment before. <input type="radio"/> 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		<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"/> My unfulfilled wish of having a child is stressing me mentally and emotionally.		
Mental health	<input type="radio"/> 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	<input type="radio"/> none	<input type="radio"/> Yes, with current partner	<input type="radio"/> Yes, with previous partner
		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 therapy
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 or C		<input type="radio"/> elapsed	<input type="radio"/> acut <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"/> My unfulfilled wish of having a child is stressing me mentally and emotionally.	
	<input type="radio"/> 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)						<input type="radio"/> Yes	<input type="radio"/> No	
Cryocycle						<input type="radio"/> Yes	<input type="radio"/> No	
Egg- or embryo donation						<input type="radio"/> Yes	<input type="radio"/> 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	<input type="radio"/> IVF	<input type="radio"/> ICSI	<input type="radio"/> IVF	<input type="radio"/> ICSI	<input type="radio"/> IVF	<input type="radio"/> ICSI	<input type="radio"/> IVF	<input type="radio"/> 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	<input type="radio"/> Day 2-3 <input type="radio"/> Day 4-6	<input type="radio"/> Day 2-3 <input type="radio"/> Day 4-6	<input type="radio"/> Day 2-3 <input type="radio"/> Day 4-6	<input type="radio"/> Day 2-3 <input type="radio"/> Day 4-6	<input type="radio"/> Day 2-3 <input type="radio"/> Day 4-6			
Outcome of treatment								
The following additional methods were used during one or more of the treatment cycles	<input type="radio"/> Embryogluce <input type="radio"/> Assisted hatching (AHA) <input type="radio"/> Physiological ICSI (pICSI) <input type="radio"/> Polar body biopsy <input type="radio"/> 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)