

No.

In order to provide correct evaluation and successful personalized treatment plan, the medical team needs extensive details about factors involved. We recommend that you fill in as much information as possible. Please attach all relevant documentation to this form, such as reports of previous treatments, examinations, operations.

All answers are voluntary and strictly confidential. You can send us the form via email: programari@gynera.ro

Patient personal information

Surname	Name
Date of birth	ID
Address	
Phone number	Email
Occupation	Employer
Public medical insurance	Private medical insurance
Married <input type="checkbox"/> No <input type="checkbox"/> Yes, since	

Partener personal information

Surname	Name
Date of birth	ID

Addressability

Reason for consultation
You came to <input type="checkbox"/> Gynera clinic <input type="checkbox"/> Specific doctor
How did you find about Gynera / the doctor?
Referring doctor

Medical information

Height	Weight				
Smoker	<input type="checkbox"/> No <input type="checkbox"/> Yes	cigarettes/day	Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Toxic environment	<input type="checkbox"/> No <input type="checkbox"/> Yes		Excessive heat exposure	<input type="checkbox"/> No <input type="checkbox"/> Yes	
Other toxicants					

Pregnancies with current partner	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pregnancies with other partner	<input type="checkbox"/> No <input type="checkbox"/> Yes
Children			
Year of birth	<input type="checkbox"/> Current partner <input type="checkbox"/> Other partner	<input type="checkbox"/> Healthy	
Year of birth	<input type="checkbox"/> Current partner <input type="checkbox"/> Other partner	<input type="checkbox"/> Healthy	
Year of birth	<input type="checkbox"/> Current partner <input type="checkbox"/> Other partner	<input type="checkbox"/> Healthy	

Current medication, including herbal	<input type="checkbox"/> No <input type="checkbox"/> Yes
Allergies	<input type="checkbox"/> No <input type="checkbox"/> Yes

Did you ever have?				
Chlamydia	Papilloma virus (HPV)	Thyroid disease	Hypertension	Transfusion
Gonorrhoea	Other genital infections	Cancer	Asthma	Thrombosis
Herpes	Inguinal hernia	Diabetes	Urinary infections	Vaccinations
Hepatitis	Testicular tumor	Cardiac disease	Difficulty to produce sperm	
TBC	Varicocoele	Liver disease	Weight variations	
	Undescended testis	Renal disease	Anaesthetic, if yes, any complication:	
Erection / ejaculation problems			Steroid administration	

Medical history - others

Previous surgery

Urinary tract
Undescended testis
Testicular tumor
Varicocoele
Testicular biopsy PESA/MESA/TESE
Other

Family history (diabetes, cancer, genetic diseases, cardiac diseases, hypertension, malformations thrombosis, embolism etc)

Family history of spontaneous abortion No Yes

Infertility No Yes, since _____ (Unprotected intercourse)

Previous investigations Known cause No Yes

Semen analysis	Yes, in year	Result
Semen culture	Yes, in year	Result
Urethral culture	Yes, in year	Result
FSH	Yes, in year	Result
TSH	Yes, in year	Result
Prolactine	Yes, in year	Result
Testosterone	Yes, in year	Result
Genetic tests	Karyotype	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
	Y CRS Microdeletions	<input type="checkbox"/> Absent <input type="checkbox"/> Present
Others		

Urologic examination	Yes, in year	Result

Significant treatments

Hormone treatment	Yes, in year	Medication
Others	Yes, in year	Treatment
Complications	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Date _____

Signature