Health declaration concerning infertility, woman:

Name: ....

Personal number: .... Phone number: ....

I give my consent that the reproduction centre can take part of my hospital records from other healthcare providers ***Your consent is needed to do a complete investigation and clinical assessment.*** Yes No

Ethnicity. I come from: ....

For how long have you been a couple? Living together since? ....

For how long have you been trying to have a child? ....

Previous investigation or treatment for infertility? ....

Civil status: Married Cohabitation

Occupation ....

Intercourse (frequency, pain etc.) ....

Hereditary diseases in your family? ....

Previous/current physical or psychological diseases: ....

Previous gynaecological health problems and/or surgery (medical and non-medical procedures)

....

Previous sexually transmitted diseases: ....

Pregnancies in current relationship:

Number .... Miscarriage .... Abortion........... Ectopic pregnancy.......... Children ....

Previous pregnancies:

Number .... Miscarriage .... Abortion........... Ectopic pregnancy.......... Children ....

Number of days from the first day of the period until the first day of the next period: ....

The shortest and the longest menstrual interval at irregular periods: ....

Menstrual pain requiring medication at each menstruation: Yes No

Current gynaecological health problems: ....

Last cervical smear: .... Abnormal Yes No

Current medications: .... Allergies: ....

Previous or current abuse of alcohol, medications or other drugs: ....

Due to the risk of contagious diseases that can affect pregnancy and treatment, we wonder if you within the latest 6 months have travelled or had a longer stay abroad or if you plan to do so.

If so, when and where? ....

Have you been involved in an accident in the last 3 months (which has led to surgery, hospitalization, blood transfusion etc.)? ....

Have you been vaccinated in the last 3 months? ....

Weight (kg): .... Height (cm): ....

Date: .... Signature: ....