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 Yes □ No □

Your consent is needed to do a complete investigation and clinical assessment.

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: ……

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 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……