

Health declaration concerning infertility, same-sex couple:

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 desired to have a child?

Which one of you is supposed to undergo treatment?

Previous investigation or treatment for infertility?

Civil status: Married Cohabitation

Occupation.....

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.....