Health declaration

Name:	Social security number:	
Name and social security number of partner *(if applicable)*:		
Address:		
Mobile number:	E-mail:	
Marital status: Married ❑ Partner ❑ Single ❑	If married/partner, are you registered at the same address? No ❑ Yes ❑	
Profession/Occupation:	Height: cm	Weight: kg

Current and passed diseases

	No	Yes		No	Yes
Blood clot	❑	❑	Depression (medically treated)	❑	❑
Bleeding tendency	❑	❑	Thyroid disease (metabolism)	❑	❑
Heart or lung diseases	❑	❑	Abdominal or gynecological surgery	❑	❑
Jaundice (hepatitis)	❑	❑	Gynecological disease	❑	❑
Diabetes	❑	❑	Disease/surgery in the urinary tract	❑	❑
Rheumatic disease	❑	❑	Lower abdomen disease (e.g., Chlamydia, Gonorrhea, Prostatitis)	❑	❑
Kidney disease	❑	❑	Other serious illness	❑	❑

Hereditary diseases in the immediate family? ❑ No ❑ Yes
If yes, which?

Do you take any medications? No ❑ Yes ❑ If yes, which ones?	Any allergies? No ❑ Yes ❑ If yes, against what?	Vaccinated beyond the vaccination program? No ❑ Yes ❑ If yes, when and against what?

Habits and risks

Do you smoke? No ❑ Yes ❑	If yes, for how long?	Number of packages/week
Do you use 'snus'? No ❑ Yes ❑	If yes, for how long?	Number of 'dosor'/week
Do you drink alcohol? No ❑ Yes ❑	If yes, for how long?	Number of standard glasses/week
Do you use drugs? No ❑ Yes ❑	If yes, which ones and for how long?	
Do you or have you used anabolic steroids/testosterone preparations? No ❑ Yes ❑ If yes, when and for how long?		
Have you been in situations where you´ve risked blood infections? (e.g., injection drug use) No ❑ Yes ❑		
In the past 3 months, have you received a blood transfusion, got tattooed or pierced or received acupuncture? No ❑ Yes ❑		
Have you been in situations where you´ve risked a sexually transmitted infection? No ❑ Yes ❑		
Have you had a significant accident that required medical attention? No ❑ Yes ❑ If yes, comment:		
Have you stayed abroad at any time during the last 6 months? No ❑ Yes ❑ If yes, where?		
During that time, have you received care or worked within health care abroad? No ❑ Yes ❑ If yes, where?		

TURN

Nordic IVF Stockholm IVF

Do you or your parents come from, or have you previously had an intimate relationship with a person from one of the following areas: Africa, South and Central America, the Caribbean, the small island groups in Oceania (Vanuatu, the Solomon Islands, etc.), Romania, Iran or Japan?
No ❑ Yes ❑ If yes, comment:

Ethnic origin:

Answer the following questions that are relevant to you:

Menstrual interval? (Number of days from the first day of the period to the first day of the next period)

Date of your last period:	Have you used ovulation tests No ❑ Yes ❑	What was the result of the test? Positive ❑ Negative ❑
Are you or have you been treated for cell changes? (conized) No ❑ Yes ❑ If yes, which year?		Date of your last pap smear:

Have you had mumps?
No ❑ Yes ❑ If yes, did you have severe testicular swelling?

Enter the following in the current relationship: How long have you been trying to conceive?

Number of pregnancies:	Number of children: Born year:	Number of miscarriages:	Number of abortions:

Enter the following in previous relationships:

Number of pregnancies:	Number of children: Born year:	Number of miscarriages:	Number of abortions:

Enter the following as single:

Number of pregnancies:	Number of children: Born year:	Number of miscarriages:	Number of abortions:

Was any pregnancy and delivery normal?
No ❑ Yes ❑ If no, in which way?

Have you previously undergone any investigation or treatment for infertility? No ❑ Yes ❑
If yes, when and at which clinic? Number of times?

Was the semen sample assessed as normal?
No ❑ Yes ❑

Any other information that could be of value to us?

How did you find out about our clinic?
Recommendation ❑ Google ❑ Social media ❑ Advertising❑ Ladies Circle ❑ GoFrendly ❑ Other ❑

❑ *I certify that I understand the information that existing infection and disease can be transferred to the recipient (the person who intends to carry the child) and any children during fertility treatment. I have had the opportunity to ask questions and have received answers. I certify that the information I have provided is truthful.*

Date & signature: