Health Declaration

Processing of personal data in connection with the Health Declaration

Nordic IVF processes your personal data in connection with your submission of the Health Declaration. The data is saved in our patient administrative system (medical records), which forms the basis for your health certificate. For more information on how we process your personal data, see www.nordicivf.se/integritetspolicy.

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

Current and past diseases

	No	Yes	Year		No	Yes	Year
Deep vein thrombosis	❑	❑		Mental depression (requiring treatment)	❑	❑	
Bleeding tendency	❑	❑		Thyroid disease	❑	❑	
Heart or lung disease	❑	❑		Abdominal or gynecologic surgery	❑	❑	
Hypertension	❑	❑		Gynecological disease	❑	❑	
Jaundice (hepatitis)	❑	❑		Urinary tract disease/surgery	❑	❑	
Diabetes	❑	❑		Genital disease (Chlamydia, Gonorrhea, Prostatitis)	❑	❑	
Rheumatic disease	❑	❑		Other serious illness	❑	❑	
Kidney disease	❑	❑					

Hereditary diseases in close relatives? ❑ No ❑ Yes If yes, which?	How would you rate your overall health?	
Do you take any medications? No ❑ Yes ❑ If yes, which?	Do you have any allergies? No ❑ Yes ❑ If yes, against what?	Are you vaccinated beyond the standard vaccination program? No ❑ Yes ❑ If yes, against what and when?

Habits and risk behavior

Do you smoke? No ❑ Yes ❑	If yes, since when?	Number of packages per week
Do you use snus? No ❑ Yes ❑	If yes, since when?	Number of boxes per week
Do you drink alcohol? No ❑ Yes ❑	If yes, how many standard glasses per week?	
Do you use drugs? No ❑ Yes ❑	If yes, which, and since when?	
Do you currently use or have you ever used anabolic steroids or testosterone preparations? No ❑ Yes ❑ If yes, when and for how long time?		
Do you or your parents come from, or have you previously had a sexual relation with a person from any of the following areas: Africa, South or Central America, Caribbean, small Oceanian islands (eg Vanuatu, Solomon Islands), Romania, Iran, or Japan? No ❑ Yes ❑ If yes, please comment:		

Risk behavior **during the last 6 months**:

Have you been exposed to a risk of blood infection? (eg drug injection abuse) No ❑ Yes ❑
Have you received a blood transfusion, been tattooed or pierced, or received acupuncture? No ❑ Yes ❑

Risk behavior **during the last 6 months** (cont'd):

Have you been exposed to a risk of sexually transmitted disease? No ❑ Yes ❑	How many sexual partners have you had? Number:
Have you had any accident needing hospital admission? No ❑ Yes ❑ If yes, where and when?	Which type of accident?
Have you had any medical or non-medical operation/intervention? No ❑ Yes ❑ If yes, where and when?	Which type of operation?
Have you stayed abroad a shorter or longer period? No ❑ Yes ❑ If yes, where?	If yes, have you been treated or worked in a medical care system abroad? No ❑ Yes ❑ If yes, where?

Answer those of the following questions that are relevant to you:

Menstrual intervals (number of days between first day of consecutive menstruations):			
Date of last period:	Have you used ovulation tests? No ❑ Yes ❑	Result of test? Positive ❑ Negative ❑	
Have you been treated for cervical cell changes? (eg conization) No ❑ Yes ❑ If yes, which year?		Date of last Pap smear:	
Have you had mumps? No ❑ Yes ❑ If yes, did you have severe testicular swelling?			
Related to your current partnership: For how long have you tried to conceive?			
No. of pregnancies:	No. of children: Year of birth(s):	No. of miscarriages:	No. of abortions:
Related to your previous partnerships:			
No. of pregnancies:	No. of children: Year of birth(s):	No. of miscarriages:	No. of abortions:
Related to your single status:			
No. of pregnancies:	No. of children: Year of birth(s):	No. of miscarriages:	No. of abortions:
Have your pregnancies and deliveries been normal? No ❑ Yes ❑ If no, in what way not normal?			
Have you previously had any workups or treatments for infertility? No ❑ Yes ❑ If yes, when and at which clinic?		No. of treatments:	
Was the semen sample normal? No ❑ Yes ❑			
Do you have any more information that you believe is of value to us?			

Information to our clinics:

How were you made aware of our clinic? Recommendation ❑ Google ❑ Social media ❑ Advertisement ❑ Ladies Circle ❑ GoFrendly ❑ Other ❑
❑ I agree that Nordic IVF & Stockholm IVF may send me an e-mail regarding a request to write a review. Your e-mail address will be deleted no later than 6 months after the date specified below, according to our privacy policy; See www.nordicivf.se/integritetspolicy

❑ *I declare that I am aware that during fertility treatment, the recipient (the person who will carry the child) or child may contract an infection or disease that already exists. I have had the opportunity to ask questions and have received answers. I certify that the information I have provided is truthful.* ❑ *I approve that the clinic may gain access to my medical records and test results from other healthcare providers.*
Date & signature:

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