



MELIVA

Health declaration - **Male**

Date:

| | | | |
|---|--|--|--|
| Name: | | Personal id number: | |
| Name of partner: | | Personal id number: | |
| Phone number | | | |
| Address: | | | |
| Marital status: | Married <input type="checkbox"/> | Partners <input type="checkbox"/> | How long have you been in this relationship? |
| Registered in Stockholms län? No <input type="checkbox"/> Yes <input type="checkbox"/> | | | |
| Profession/employment: | | | |
| Smoking: No <input type="checkbox"/> Yes <input type="checkbox"/> | | Snus: No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Cig/day: How long: | | Snus/day: How long: | |
| Alcohol? No <input type="checkbox"/> Yes <input type="checkbox"/> | | Have you used or are currently using anabolic steroids | |
| Amount/week: | | No <input type="checkbox"/> Yes <input type="checkbox"/> | |
| Other addiction: | No <input type="checkbox"/> Yes <input type="checkbox"/> | Which one: | Current weight: Height: |
| Heredity: | | | BMI: |
| Past or present illness/disease | No | Yes | Year |
| Diabetes | | | |
| Hypertension | | | |
| Heart disease | | | |
| Lung disease | | | |
| Hemophilia | | | |
| Reumatic disease | | | |
| Jaundice/hepatitis? | | | |
| Past or present illness/disease | | No | Yes |
| Thrombosis | | | |
| Kidney disease | | | |
| Abdominal surgery | | | |
| Depression (medical treated) | | | |
| Other serious illness | | | |
| If yes, which one: | | | |
| Current medication: No <input type="checkbox"/> Yes <input type="checkbox"/> Medications: | | | |
| Allergies: No <input type="checkbox"/> Yes <input type="checkbox"/> Against: | | | |
| Hypersensitivity to drugs: No <input type="checkbox"/> Yes <input type="checkbox"/> Which one: | | | |

Andrological health declaration

| | | | |
|---|-----------------------------|------------------------------|---|
| Previously genital surgery men, eg inguinal hernia, scrotocele, testicular hernia | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Previously venereal disease / STD | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Urinary infection | No <input type="checkbox"/> | Yes <input type="checkbox"/> | When: Tenderness in testis/scrotum |
| Number of years of infertility | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Pregnancies in earlier relationships | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Pregnancies in current relationship | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Children: | Miscarriages: | Ectopic pregnancies: | Abortions: |
| Ever left semen sample: | | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| When: | | Where: | |
| How was the result of your semen sample? (E.g. normal, fewer sperm, reduced mobility etc) | | | |

Consent to read my medical journals No Yes

Consent that my personal id number and name are written in my partners medical journals No Yes

Signature:
