MELIVA

Health declaration – **Female independent** Date:

Name:				Personal id number:			
Address:				Phone number:			
Profession/employment:				Extract from the population register No ☐ Yes ☐			
Independent >1 year No ☐ Yes ☐				Guardian of children No ☐ Yes ☐			
Smoking No ☐ Yes ☐ Cigs/day: How long:				Snus: No ☐ Yes ☐ Snus/day: How long:			
Alcohol? No ☐ Yes ☐ Amount/week:							
Other addiction No ☐ Yes ☐				Which one:			
Current weight:				Height:			
Heredity:				BMI:			
Past or present illnes/disease	No	Yes	Year	Past or present illnes/disease	No	Yes	Year
Diabetes				Thrombosis			
Hypertension				Kidney disease			
Heart disease				Abdominal surhery			
Lung disease				Depression (medical treated)			
Hemophilla							
Reumatic disease				Other serious illnesses			
Jaundice/hepatitis?				If yes, which one:			
Current medication:	No ☐	Yes ☐		Medication:			
Allergies:	No ☐	Yes ☐		Against:			
Hypersensitivity to drugs:	No ☐	Yes ☐		Which:			

Gynecological health declaration

Previously gynecological disease	No ☐	Yes ☐		
Previously gynecological surgery	No ☐	Yes ☐		
Previously veneral disease / STD	No ☐	Yes ☐	Testing for chlamydia via 1177	No ☐ Yes ☐
Year of last taken pap smear:			Normal?	No ☐ Yes ☐
Number of years of infertility:				
Current relationship Number of pregnancies:	Children:	Misscarriages:	Ectopic pregnancies:	Abortions:
Days between the first day of bleeding until next menstruations first day:			How many days of bleeding?	
Date of last menstruation:	Period pain:	None ☐	Mild ☐	Moderate ☐ Severe ☐
	Pain killers:			

Have you previously undergone an infertility assessment?	No ☐	Yes ☐	
Previous insemination:	No ☐ Yes ☐	Which clinic:	
When:	How many times:		
Previous hormone treatment:	No ☐ Yes ☐	Which clinic	
When:	How many times:		
Previous IVF:	No ☐ Yes ☐	Which clinic:	
When:	How many times:		

I agree that the business takes part of unobstructed medical records from other care providers necessary to be able to provide good and safe care No ☐ Yes ☐

Signature:

_____