

To be filled in by the MAN

| Name: | | Social security number: | | | | | |
|--|--------------------------------------|--|-----------|--|--|--|--|
| Name of the partner: | | Social security number: | | | | | |
| Address: | | Telephone number: Email address: | | | | | |
| Marital status: Married Marring together | | | | | | | |
| | gether, are you registered on the | | | | | | |
| Profession/Employment: | | Length: | Weight: | | | | |
| For how long have yo | pu been a couple? | | | | | | |
| For how long have yo | ou tried, as a couple, to get pregna | ant? | | | | | |
| Current and passed diseases: If yes for any of diseases below, please describe what and when here: | | | | | | | |
| Blood clotting | No / Yes | Kidney disease | No / Yes | | | | |
| Bleeding tendency | No / Yes | Rheumatic disease | No / Yes | | | | |
| Abdominal/Genital surgery | No / Yes | Thyroid disease | No / Yes | | | | |
| Psychiatric | No / Yes | Lower abdomen disease/ | No / Yes | | | | |
| disease/ | | Genital disease | 100 / 103 | | | | |
| depression | | | | | | | |
| (treated) | | | | | | | |
| Diabetes | No / Yes | Urinary tract infection | No / Yes | | | | |
| Jaundice/liver | No / Yes | Hereditary disease | No / Yes | | | | |
| disease | | | | | | | |
| Heart disease | No / Yes | Other serious disease | No / Yes | | | | |
| Lung disease | No / Yes | | No / Yes | | | | |
| Do you take any medication: No 🗌 Yes 🗌 | | Do you have any allergies/hypersensitivity: No 🗌 Yes 🗌 | | | | | |
| If yes, what do you ta | ake: | If yes, against what: | | | | | |
| Are you vaccinated a | | s 🗌 Hepatitis B No 🗌 Yes | | | | | |
| (Mumps vaccine is included in the child vaccination program) | | | | | | | |
| Do you feel any soreness in your testicles: No 🗌 Yes 🗌 | | | | | | | |
| Have you had any pregnancies together with current Pregnancies in other relationships: | | | | | | | |
| partner: | | Total pregnancies: Children: | | | | | |
| Total pregnancies: Children: | | | | | | | |
| Have you done an infertility investigation or IVF treatments before? No Yes Yes | | | | | | | |
| If yes, at which clinic: | | | | | | | |
| Have you previously left a sperm sample: No 🗌 Yes 🗌 If yes, when: | | | | | | | |
| Was the sperm sample normal at the time: No \Box Yes \Box | | | | | | | |

Please turn page!



Living habits during present and the last 6 months

(requirements of questions from IVO, the Health & Social Care Inspectorate)

| Smoking | No / | Anabolic steroids or other drugs (now | No / Yes | | | |
|---|------------------------------------|--|-----------------|--|--|--|
| (current situation) | Yes, cigarettes/ day | and earlier in life) | | | | |
| Snus (Snuff) | No / | Have you during the last 6 months been | No / Yes | | | |
| (current situation) | Yes, portions/ day | in a situation where you have been at risk for transmission of infections (by blood)? | | | | |
| Alcohol | No / | Have you during the last 6 months been | No / Yes | | | |
| (current situation) | Yes, times/ week | in a situation where there was a risk for sexually transmitted disease (STD)? | | | | |
| How many sexual partners have you had during the last 6 months? | | | | | | |
| of the following areas: Africa, South and Central America, the Caribbean, the small island groups in Oceania (the Solomon Islands, etc.), Romania, Iran or Japan? Have you been abroad sometime during the last 6 months? Have you during the last 12 months worked at or been in contact with a hospital abroad: No Yes Have you during the last 12 months worked at or been in contact with a hospital abroad: If yes, when and where: | | | | | | |
| Have you during the | last 6 months had a significant ac | cident that required medical attention? | | | | |
| No 🗆 Yes 🗆 | Describe: | | | | | |
| piercing, acupunture | • | rgical medical procedures (cosmetic procedu cal procedures (like beauty operations? | ires, tattooes, | | | |

| Is there anything else you want to add? | | | | | | | | |
|---|--------------------------|--------------------------|----------|--------------|--|--|--|--|
| How did you get to know about our clinic: | | | | | | | | |
| Recommendation | By another clinic \Box | Social media $\ \square$ | Google 🗌 | Other \Box | | | | |
| □ I agree to let Göteborgs IVF klinik contact me regarding the invitation to write a review. | | | | | | | | |
| □ I agree to let the clinic receive my test results from another healthcare provider. | | | | | | | | |
| | | | | | | | | |
| I hereby confirm that I understand the information given about infections and diseases is vital since infections/STD also could be transmitted through biological material to the mother and child (by IVF). I have had the opportunity to ask questions and have gotten satisfactory answers to these. I hereby confirm that the information above is truthful. | | | | | | | | |
| Date and Signature | | | | | | | | |