GYNEKOLOG & FERTILITETSCENTER — SWEDEN —

GÖTEBORGS — IVF KLINIK —

To be filled in by the <u>WOMAN</u>

Name:		Social security number:	
Name of the partner (if you have):		Social security number:	
Address:		Telephone number: Email address:	
Marital status: ☐ Married ☐ Living together ☐ Single If married or living together, are you registered on the same address? No ☐ Yes ☐			
Profession/Employment:		Length:	Weight:
If you have a partner, for how long have you been a couple?			
How long have you tried, as a couple, to get pregnant?			
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/Gynecological surgery	No / Yes	Thyroid disease	No / Yes
Psychiatric disease/ depression (treated)	No / Yes	Lower abdomen disease/ Genital disease	No / Yes
Diabetes	No / Yes	Urinary tract infection	No / Yes
Jaundice/liver disease	No / Yes	Hereditary disease	No / Yes
Heart disease	No / Yes	Other serious disease	No / Yes
Lung disease	No / Yes	Gynecological disease	No / Yes
		Gynecological surgery	No / Yes
Do you take any medication: No ☐ Yes ☐ If yes, what do you take:		Do you have any allergies/hypersensitivity: No ☐ Yes ☐ If yes, against what:	
Have you earlier suffered from blood clutting? No ☐ Yes ☐ Have you taken anticoagulants, like fragmin, trombyl, innohep, eliquis, xarelto, klexane? No ☐ Yes ☐ Have you any heredity for blood clutting? No ☐ Yes ☐ I yes, what kind of heredity?			
Are you vaccinated against: Rubella No ☐ Yes ☐ Hepatitis B No ☐ Yes ☐ (Rubella vaccine is included in the child vaccination program)			
Are you vaccinated against anything else than described above? ☐ No ☐ Yes, please describe:			
When did you take your last pap smear/cytology sample? Year: Normal: No ☐ Yes ☐			
Menstrual interval = number of days from the first day of your period to the first day of your next period:			
Date of first day of last period:		If you tried ovulation strips to test if you have had ovulation, what was the result? Positive ☐ Negative ☐	
If you use ovulation (LH)-test to test if you have had ovulation, at what day in your cycle does it usually turn positive?			
Have you had any pregnancies with current partner: Total number of pregnancies: Children: Miscarriage: Ectopic pregnancy: Abortion/s:			
Pregnancies in other relationships: Total number of pregnancies: Children: Miscarriage: Ectopic pregnancy: Abortion/s:			
If you have given birth, was the pregnancy and delivery normal? No ☐ Yes ☐ If no, in what way?			
Have you done an infertility investigation, hormonal treatment or IVF treatment before? No ☐ Yes ☐ If yes, at which clinic: When: Number of treatments:			

Please turn page!

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Living habits during present and the last 6 months
(requirements of questions from IVO, the Health & Social Care Inspectorate)

Smoking (current situation)	No / Yes, ____ cigarettes/ day	Anabolic steroids or other drugs (now and earlier in life)	No / Yes
Snus (current situation)	No / Yes, _____ doses/ week	Have you during the last 6 months been in a situation where you have been at risk for transmission of infections (by blood)?	No / Yes
Alcohol (current situation)	No / Yes, _____ times/ week	Have you during the last 6 months been in a situation where there was a risk for sexually transmitted disease (STD)?	No / Yes
How many sexual partners have you had during the last 6 months?			
Do you or your parents come from, or have you previously in life 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 (the Solomon Islands, etc.), Romania, Iran or Japan? ☐ No ☐ Yes			
Have you been abroad sometime during the last 6 months? ☐ No ☐ Yes If yes, when and where:			
Have you during the last 12 months worked at or been in contact with a hospital abroad: ☐ No ☐ Yes If yes, when and where:			
Have you during the last 6 months had a significant accident that required medical attention? No ☐ Yes ☐ Describe:			
Have your during the last 6 months performed non-surgical medical procedures (cosmetic procedures, tattooes, piercing, acupunture, blood transfusions) or non medical procedures (like beauty operations? No ☐ Yes ☐, describe:			

Is there anything else you want to add?
How did you get to know about our clinic: Recommendation ☐ By another clinic ☐ Social media ☐ Google ☐ Other ☐
☐ 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