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 ☐ Living together If married or living together, are you registered on the same address? No ☐ Yes ☐ If yes, since when?			
Profession/Employment:		Length:	Weight:
For how long have you been a couple?			
For 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/Genital 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		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 clotting? No ☐ Yes ☐ Have you taken anticoagulants, like fragmin, trombyl, innohep, eliquis, xarelto, klexane? No ☐ Yes ☐ Have you any heredity for blood clotting? No ☐ Yes ☐ I yes, what kind of heredity?			
Are you vaccinated against: Mumps No ☐ Yes ☐ 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 partner: Total pregnancies: Children:		Pregnancies in other relationships: Total pregnancies: Children:	
Have you done an infertility investigation or IVF treatments before? No ☐ Yes ☐ If yes, at which clinic: When: Number of treatments:			
Have you previously left a sperm sample: No ☐ Yes ☐ If yes, when:			
Was the sperm sample normal at the time: No ☐ Yes ☐			

Please turn page!

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 (Snuff) (current situation)	No / Yes, _____ portions/ day	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? 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 and complete. ☐I promise to inform my treating doctor if any new have arisen from today and until start of treatment. Date and Signature