



Health declaration concerning infertility

Questions for the woman

Name: _____

Personal number: _____

Height _____ (cm)

Weight _____ (kg)

What do you do during the day? If you work, what is your profession?

How many times have you been pregnant? _____

Of these, how many resulted in live births? _____

How many shared pregnancies have you had? _____

How many shared children to you have? _____

How long have you been a couple with your partner? _____

How long have you been trying to have a child? _____ years.

Your average menstrual interval is _____ days.

If you have irregular periods, enter the shortest menstrual interval: _____ days; and the longest interval: _____ days.

Do you have menstrual pain requiring medication at each menstruation? _____

Do you have pain during intercourse? _____

Have you ever had a sexually transmitted disease (e.g. chlamydia)?

If so, please specify _____

Have you ever had any gynaecological diseases?

If so, please specify _____

Have you ever had gynaecological or abdominal surgery, e.g. dilation and curettage (D&C) or keyhole surgery? If so, please specify what the surgery was and when it occurred:

Have you ever had an abnormal cervical smear? _____



When did you last have a cervical smear? _____

Do you currently have or have you ever had any other diseases?

If so, please specify: _____

Do you take any medications on a daily basis? If so, please specify:

Do you have any allergies?

Have you undergone any investigation or treatment for infertility previously?

Are there any hereditary diseases in your family? If so, please specify:

Do you have a history of abuse of alcohol, medications or other drugs?

Have you had or do you currently have any psychological disorders?

Lifestyle

Questions for the woman

Do you smoke? __ If so, how many cigarettes/day?

- ☐ 1-10 cigarettes/day
- ☐ 10-20 cigarettes/day
- ☐ ≥ 20 cigarettes/day

Do you take snuff? __ If so, how many doses/week?

- ☐ 1-2 doses/week
- ☐ 3-4 doses/week
- ☐ ≥ 4 doses/week

Yes, I agree that the reproduction centre can requisition and use my records.

Location and date _____

Signature _____



Health declaration concerning infertility

Questions for the man

Name: _____

Personal number: _____

Height _____ (cm)

Weight _____ (kg)

What do you do during the day? If you work, what is your profession?

How many shared pregnancies have you had with your partner? ____ Of these, how many shared children do you have? _____

Do you have any children from earlier relationships? _____

Have you ever had any genital disorders or sexually transmitted diseases?

Do you have any problems with ejaculation? _____

Do you have any erection problems? _____

Do you have or have you ever had any other diseases?

If so, please specify: _____

Are you taking any medications on a daily basis?

If so, please specify: _____

Do you have any allergies? _____

Have you undergone any investigation or treatment for infertility previously?

Are there any hereditary diseases in your family?

If so, please specify _____

Do you have a history of abuse of alcohol, medications or other drugs?

Have you had or do you currently have any psychological disorders?



Lifestyle

Questions for the man

Do you smoke? _____ If so, how many cigarettes/day?

- ☐ 1-10 cigarettes/day
- ☐ 10-20 cigarettes/day
- ☐ ≥ 20 cigarettes/day

Do you take snuff? _____ If so, how many doses/week?

- ☐ 1-2 doses/week
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Yes, I agree that the reproduction centre can requisition and use my records.

Location and date _____

Signature _____