Cevita CARE GynStockholm

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 ☐			Snus: No ☐ Yes ☐		Alcohol? No ☐ Yes ☐		
Cigs/day: How long:			Snus/day: How long:		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:

_____