göteborgs KVINNOKLINIK

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|---|---|---|---|
| **Name** | | **Date of birth** | |
| **Name of eventual partner** | | **Date of birth** | |
| **Address** | | **Phone number** | |
| **Civil status**<br>Married ❑ Partner ❑ Single ❑ | | **Are you both registered at the same address?**<br>No ❑ Yes ❑ | |
| **Profession** | | **Height**<br>cm | **Weight**<br>kg |
| **Smoke?**<br>❑ No ❑ Yes<br>Cigarettes/day | **Snuff or other tobacco?**<br>❑ No ❑ Yes<br>Boxes/week | **Alcohol?**<br>❑ No ❑ Yes<br>Drinks/week | **Drugs?**<br>❑ No ❑ Yes<br>Which ones? |

**Are there any hereditary diseases in your immediate family?** ❑ No ❑ Yes

If yes, which ones?

**Previous illnesses?** ❑ No ❑ Yes

| | | | | | |
|---|---|---|---|---|---|
| Blood clot | ❑No | ❑Yes | Abdominal or gynaecological surgery | ❑No | ❑Yes |
| Haemorrhagic disorder | ❑No | ❑Yes | Gynaecological disease | ❑No | ❑Yes |
| Heart- or lung disease | ❑No | ❑Yes | Kidney disease | ❑No | ❑Yes |
| Hepatitis | ❑No | ❑Yes | Depression (medically treated) | ❑No | ❑Yes |
| Diabetes | ❑No | ❑Yes | Thyroid disease (metabolism) | ❑No | ❑Yes |

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|---|---|
| **Medication taken regularly?** ❑ No ❑ Yes<br>If yes, name of the medicine: | **Any allergies?** ❑ No ❑ Yes<br>If yes, to what? |
| **Are you vaccinated against:**<br>Rubella ❑ No ❑ Yes<br>Hepatitis B ❑ No ❑ Yes | **Any other vaccination during the last 6 months?** No ❑ Yes ❑<br>If yes, against which disease? |

**Menstrual interval?** (first day of menstruation until the next first day of menstruation)

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|---|---|
| **Last menstrual period?** | **Have you been using ovulation tests?** ❑ No ❑ Yes<br>If yes, what was the result? ❑ Positive ❑ Negative |

**Have you ever received treatment due to an abnormal Pap smear?** ❑ No ❑ Yes

**Previous gynaecological diseases?** ❑ No ❑ Yes

If yes, which one? ❑Chlamydia ❑ Gonorrhoea ❑ Other

**Have you gone through an infertility investigation, hormonal or IVF treatment?** ❑ No ❑ Yes

If yes, at which clinic? When? Number of times?

**Previous pregnancy?** ❑ No ❑ Yes

If yes, how many?

| | | |
|---|---|---|
| If yes, number of children? | Date of birth | If yes, was the pregnancy and delivery normal?<br>❑ No ❑ Yes |

**Have you traveled outside Europe during the last 6 months?** ❑ No ❑ Yes

If yes, which country?

**Have you been treated in a hospital abroad any time during the last 6 months?** ❑ No ❑ Yes

**How did you hear about our clinic?**

Recommendation ❑ Google ❑ Social media ❑ Ad ❑ Other ❑

**Is there anything else that you think would be important for us to know?** (Write at the back of the paper)

**Date & Signature**

**Göteborgs Kvinnoklinik**
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