göteborgs KVINNOKLINIK

(WOMAN)

Name (woman)		**Date of birth**	
Name (partner)		**Date of birth**	
Address		**Phone number**	
Civil status Married ❑ Partner ❑		**Are you both registered at the same address?** No ❑ Yes ❑	
Profession		**Height** cm	**Weight** kg
Smoke? ❑ No ❑ Yes Cigarettes/day	**Snuff or other tobacco?** ❑ No ❑ Yes Boxes/week	**Alcohol?** ❑ No ❑ Yes Drinks/week	**Drugs?** ❑ No ❑ Yes 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

Medication taken regularly? ❑ No ❑ Yes If yes, name of the medicine:	**Any allergies?** ❑ No ❑ Yes If yes, to what?

Are you vaccinated against:

Rubella	❑ No	❑ Yes
Hepatitis B	❑ No	❑ Yes

Any other vaccination during the last 6 months?

No ❑ Yes ❑ If yes, against which disease?

How long have you tried to get pregnant?

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

Last menstrual period?	**Have you been using ovulation tests?** ❑ No ❑ Yes 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 ❑ with present partner? ❑ with previous partner?

If yes, how many?

If yes, number of children?	Date of birth	If yes, was the pregnancy and delivery normal? ❑ 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
Odinsgatan 10, 411 03 Göteborg
031-700 12 90
www.gbgkk.se