Barnmorskemottagningen
Mammaproffsen

Health Declaration

Name:_____
ID number: _____
Adress: _____
Mobile number:_____
Email address: _____
Country of birth:_____
Number of years living in Sweden:_____
Name of partner/next of kin: _____
Mobile number to him or her:_____

Do you live togther with your partner:	Yes	No
Married:	Yes	No
Single:	Yes	No

Other situation:_____

Proffession: _____
Company:_____

General info:
Weight:_____
Height:_____
First day of your last menstration:_____
Number of months you have tried to get pregnant:_____
Did you recieve assistance to get pregnant:_____Method:_____

Your Health history :
Have *you* had or do *you* have any of the following heath issues**:**
Allergy:_____
Blodclot:_____
Diabetes:_____
Endocrine disease such as Hypo/hyper thyreosis:_____
Epilepsy:_____
Gynecological disease/operation:_____
Heart disease: _____
Headache/migraine:_____

Hypertension:_____
Muscle/joint issues: _____
Liverdisease such as jaundice or gallblader issues:_____
Lungdisease such as astma:_____
Psycological issues: (eating disorders, Bipolarity, ADHD, anxiety, depression etc):_____
Intestinal disease: _____
Sexual Transmited Infections:_____
Tuberculosis: _____
Urin infection: _____

Disease Heredity:
Has your *mother, father* or your *siblings* had or have any of the following:
Blodclot: Yes No Who:
Hemophilia: Yes No Who:
Diabetes: Yes No Who:
Hypertension: Yes No Who:
Endocrine disease: Yes No Who:
Tuberculosis: Yes No Who:
Do you have twins in the family:_____
Do you have genetic abnormalities in the family:_____

Previous pregnancies and deliveries:
Abortions:_____ Medical or Surgical Which gestational week:_____
Miscarriages: _____Year/month:_____Hospital: _____
Deliveries:
Year/month:_____ Hospital:_____Gestational week:_____
Year/month_____Hospital:_____Gestational week:_____
Year/month_____Hospital:_____Gestational week:_____

Did you breastfeed?_____

Do you take any vitamins, pain killers or medication:_____
Do you smoke?Yes No Use Snuff: Yes No
Do you drink alkohol or abuse any drugs:Yes No'

Have you experienced physical or psykological abuse: Yes No
Have you been X-rayed or vaccinated during the pregnancy: Yes No
Have you had a blodtransfusion: Yes No When:_____Where:_____
When did you last do a papsmear: _____
Do you have MRSA: Yes No
Have you received medical care abroad in the past six months: Yes No
Have you had contact with a socialworker, therapist or psycologist?Yes No

Do you with to add anything:_____

_____

_____

Date: _____
Signature:

This information will be treated as confidential.

We welcome you to Mammaproffsen!