HEALTH DECLARATION - FEMALE

First Name and Surname	Personal ID-no or Date of Birth
First Name and Surname of partner	Personal ID-no or Date of Birth

E-mail:	*Phone:*
Profession/employment:	
Smoking: no o yes o If yes, how many cigarettes per day? *Alcohol: no o yes o If yes, how many units per week?* *Drugs: no o yes o If yes, which drugs?*	
Height:	*Body Weight:*

Previous and/or ongoing diseases	***No***	***Yes***	***Previous and/or ongoing diseases***	***No***	***Yes***
Diabetes			*Kidney disease*		
Heart disease			*Any kind of surgery*		
Pulmonary disease			*Gynecologic disease*		
Coagulation defects			*Gynecologic surgery*		
Rheumatic disease			*Sexually transmitted disease*		
Hepatitis			*Depression*		
Thrombosis			*Other disease*		

Gynecologic health declaration

Number of years with infertility:

Number of previous pregnancies:

Children: *Miscarriage:*

Extrauterin pregnancy: *Abortion:*

Number of days in your menstrual cycle:

Date when last period started:

Previous hormonal treatment: no o yes o

If yes, when and what kind of treatment?

Have you had any sexually transmitted diseases? no o yes o If yes, which disease?

Do you have any disease that theoretically might be transmitted to someone else? *no o* *yes o* *If yes, which disease?*
Have you been travelling in countries the last 12 months where infectious diseases are common, for instance Zika virus or Corona virus? *no o* *yes o* *If yes, when and to which country?*
Are you vaccinated against Hepatitis B? *no o* *yes o* *If yes, when?*
Have you had any sexual contact the last six months where you might have been exposed to a sexually transmitted disease? *no o* *yes o* *If yes, exposed to what and when?*
Do you take some medication? *no o* *yes o* *If yes, which one?*
Do you have some allergy? *no o* *yes o* *If yes, against what?*

Date and Place	*Signature and Printed Name*