HEALTH DECLARATION – MALE

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			*Testis related disease*		
Coagulation defects			*Hernia (inguinal hernia)*		
Rheumatic disease			*Sexually transmitted disease*		
Hepatitis			*Depression*		
Thrombosis			*Other disease*		

Urinary way tract infection? no o yes o If yes, when and how often? *Testis related problems? no o yes o If yes, when and any kind of treatment?* *Problems related to ejaculation? no o yes o If yes, any kind of treatment?*
Number of years with infertility:
Number of previous *Children:* *Miscarriages:*
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?
Have you used anabolic steroids? no o yes o If yes, when and how much?
Do you have some allergy? no o yes o If yes, against what?

Date and Place	*Signature and Printed Name*

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