LIVIO
Fertilitetscentrum
Umeå

In preparation for the first visit at IVF Clinic (woman)

Name:			**S S number:**
Name of partner:			**S S number:**
E-mail adress:		**Cell phone number::**	
Married: no □ yes □	**Co-habitation:** no □ yes □	How long have you been a couple:	
Occupation:			
Smoking: no □ yes □ How much: Duration:	**Chew:** no □ yes □ How much: Duration	**Alcohol** no □ yes □ How much per week?	
Length:	**Weight:**		

Earlier and/or present diseases	**No**	**Yes**	**Year**	**Earlier and/or present diseases**	**No**	**Yes**	**Year**
Diabetes				Kidney disease			
Heart disease				Abdominal operation			
Lung disease				Gynaecological disease			
Haemophilia (tendency to bleed)				Gynaecological operation			
Rheumatic disease				Venereal disease, e.g. chlamydia			
Hepatitis				Depression (medically treated)			
Thrombosis				Other serious disease			

Gynaecological health declaration

How many years of infertility:	
In present relationship Number of pregnancies: Children: Miscarriages: Ectopic pregnancy: Abortions:	
In earlier relationship Number of pregnancies: Children: Miscarriages: Ectopic pregnancy: Abortions:	
Number of days between first menstrual day and the first day of next menstrual period:	
First day of last menstrual period:	
Earlier hormone treatment: no□ yes□ Which clinic: When: Number:	
Earlier IVF: no □ yes □ Which clinic: When: Number:	
Last PAP smear	Was it normal: no □ yes □
Medication : no □ yes □ Type of medication:	
Hypersensitivity: no □ yes □ What substance:	
Hypersensitive to medication: no □ yes □	Type of medication;
Have you been treated in hospital in any other country since 1990? : no □ yes □ When? Any culture test performed?	
Any other significant information concerning your health:	

Date **Sign**