LIVIO
IVF–klinikken
Oslo

# Healt information female - English

| | | |
|---|---|---|
| **Name:** | | **Personal number:** |
| **Marital status:** Married ☐ | Cohabitant ☐ | |
| **Smoking:** No ☐ Yes ☐<br>How much:: How long: | **Snuffing/Cigs:** No ☐ Yes ☐<br>How much: How long: | **Alcohol:** No ☐ Yes ☐<br>How much per week: |
| **Height: ……..cm Weight: ……..kg** | Have you for the past 12 months been working, become a patient or done any treatment at hospitals outside of Norway? No ☐ Yes ☐ | |

| **Previous illnesses:** | **No** | **Yes** | **Year** | **Previous illnesses:** | **Yes** | **No** | **Year** |
|---|---|---|---|---|---|---|---|
| Cardiac disease | | | | Gastro-intestinal operations | | | |
| Hypertention | | | | Gastro-intestinal diseases | | | |
| Pulmonary disease | | | | Bleeding diseases | | | |
| Asthma | | | | Venous thrombosis | | | |
| Diabetes | | | | Epilepsy | | | |
| Hormonal defects: Thyroid and others | | | | Familial inherited diseases | | | |
| Urinary tract infections | | | | Reumatoid arthritis/becherew | | | |
| Kidney disease | | | | Psychological; anorrexia, bulimia, other | | | |
| Gynecologic diseases | | | | Other medicines in use | | | |
| Gynecologic operations | | | | If yes, plaese comment at back of this sheet. | | | |

| **Years of unwilling childlessness ……..years** | | |
|---|---|---|
| **Earlier pregnancies** | **Past relationship** | **Present relationship** |
| Nr of children + sex and d.o.b | | |
| Nr. spontaneous abortions; month, Year | | |
| Termination of pregnancy month, year | | |
| Extra uterine pregnancies; month, year | | |
| Adopted children, sex, age | | |
| **Date of three latest periodes:** | | |
| **Hormone treatment:** No ☐ Yes ☐ Where - clinic name:<br>When: Number of treatments: | | |
| **Earlier IVF:** No ☐ Yes ☐ Where - clinic name:<br>When: Number of treatments: | | |
| **When du you last time take a cervical smear test:** | **Normal?** Yes ☐ No ☐ | |
| **Do you take any medication?** No ☐ Yes ☐ If yes – which medication? | | |
| **Do you have any allergies:** No ☐ Yes ☐ What kind of allergy? | | |
| **Hypersensitive to medication:** N0 ☐ Yes ☐ Describe if yes: | | |
| **I have previously been involved in a child protection case:** No ☐ Yes ☐ | | |
| **Anything else we should know about you?** | | |

Date: …… Signature……