LIVIO
IVF–klinikken
Oslo

Healt information male - English

Name:	**Personal number:**
Marital status: Married ☐ Cohabitant ☐	
Smoking: No ☐ Yes ☐ How much:: How long:	**Snuffing/Cigs:** No ☐ Yes ☐ How much: How long: / **Alcohol:** No ☐ Yes ☐ 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		
Have you used or uses anabolic steroids?		
Delivered spermtest? No ☐ Yes ☐ Where/when - clinic name:		
How did the sperm be evaluated, if you have been notified? (normal/abnormal/mobility)		
Urinary tract inflammation? No ☐ Yes ☐	**Tenderness in the testicles ?** No ☐ Yes ☐	
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……