LIVIO
IVF–klinikken
Oslo

Health information male - English

Name:	**Personal number:**
Adress:	**Phone number:**

Fertility investigation/sperm test ☐
Sperm test after vasectomy ☐ **When did you do the vasectomy?**
Freezing of sperm ☐ **Reason for freezing of sperm:**
Fertility treatment with partner ☐

Marital satus: Married ☐ **Cohabitant** ☐ **Single** ☐

If married/cohabitant, partners name and personal number:

Position title:

Doctors name:
Medical center:

Have you used or use anabolic steroids? No ☐ **Yes** ☐ **If yes, when?**

Cigarettes: No☐ Yes☐ How much: How long:	**Snuffing:** No☐ Yes ☐ How much: How long:	**Alcohol:** No ☐ Yes☐ Hvor mye per uke:
Height: ……..cm Weight: ……..kg	Have hyou 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**	**If yes, comment**
Cardiac disease				
Hypertention				
Pulmonary disease				
Asthma				
Diabetes				
Hormonal defects				
Urinary tract infections				
Kidney disease				
Operations of genitalia (ie prostate surgery)				
Sexualy transmittet infections (STI)				
Orchitis (testicular infection) due to mumps				
Gastro-intestinal diseases				
Bleeding diseases				
Venous thrombosis				
Epilepsy				
Familial inherited diseases				
Reumatoid arthritis/becherew				
Psykological				
Other illnesses				

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		

LIVIO
IVF–klinikken
Oslo

Health information male - English

Extra uterine pregancies: month, year		
Adopted children + sex, age		
Delivered sperm test? No ☐ Yes ☐ When/where – clinic:		
How was the result of the sperm test? (normal/abnormal/mobility)		
Earlier IVF: No ☐ Yes ☐ Where – clinic: When: Number of treatmens:		
Urinary tract inflammation? No ☐ Yes ☐	Tenderness in the testicles? No ☐ Yes ☐	
Do you take any medications? No ☐ Yes ☐ If yes – which medication?		
Do you have any allergies? No ☐ Yes ☐ What kind of allergy?		
Hypersensitive to medication: No ☐ Yes ☐ Describe if yes:?		
I have precviously been involved in a child protection case: No ☐ Yes ☐		
Anything else we should know about you?		

Date: …… Signature: ……..