LIVIO
IVF–klinikken
Oslo

Health Declaration Form

Name:	**Personal number:**
Address and Postal code/City:	**Phone number:**

Fertility assessment ☐ **Fertility treatment** ☐ **Sperm test/freezing sperm** ☐

Marital statsus : ☐ **Married** ☐ **Cohabitant** ☐ **Single**

If married/cohabitant : partners name and date of birth	**If two women: Who is planning to be pregnant?**
Name and adress empoyer: **Job title:**	
Name of your doctor: **Medical center, name and adress:**	

Cigarettes: No ☐ Yes ☐ How much: How long:	**Snuffing:** No ☐ Yes ☐ How much: How long:	**Alcohol:** No ☐ Yes ☐ Units per week:
Height: ……..cm **Weight: ……..kg**	Have you been working, been a patient or done any treatment at hospitals outside of Norway during the last 12 months? No ☐ Yes ☐	
For women: Regular period: Yes ☐ No ☐ **Number of days from 1st day of period to 1th day of period:** **Start date of last period:**	**For women: Last cervical smear test (year):** Normal? Yes ☐ No ☐	
For men: Previous sperm analysis : Yes ☐ No ☐ **Result of sperm analysis**:	**For men: Tenderness in the testicles:** No ☐ Yes ☐ **Use of anabolic steroids:** No ☐ Yes ☐	

Previous illnesses /health status:	**No**	**Yes**	**Year**	**If yes, comments**
Cardiac disease				
Hypertention				
Pulmonary disease				
Asthma				
Diabetes				
Hormonal defects				
Urinary tract infections				
Sexually transmitted infections (STI)				
Kidney disease				
Operation of genitaliea				
Gynecologic diseases				
Gynekologic operations				
Gastro-intestinal operations				
Bleeding diseases				
Venous thrombosis				
Epilepsy				
Familial inherited diseases				
Reumathoid illness				
Phychological: anorrexia, bulimia, other				

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Previous illnesses /health status:	No	Yes	Year	If yes, comments
Other illnesses				
Medications, what kind of type?				
Allergic				
Serious allergic reaction				

Pregnancies, if relevant	Years of unwilling childlessness	Earlier pregnancies	Nr of children and d.o.b.	Nr of spontaneous abortions	Extra uterine pregnancies, year	Termination of pregnancy, year:
Present relationship						
Past relationship						
Complications past pregnancies						

Past treatment childlessness, if relevant:	Where	When	Number of treatments
Hormonal stimulation			
IVF-treatment			
Intrauterine insemination			

I have previously been involved in a child protection case: No ☐ Yes ☐
Anything else we should know about you:
How did you hear about Livio: ☐ Website ☐ Friends ☐ Doctor/gynecologist ☐ Sosial Media ☐ Recommended ☐ Other

Date:_____ Signature: _____