

## Health Declaration Woman

**According to the National Board of Health and Welfare's regulation (SOSFS 2009:30), a health declaration must be filled in and signed before possible assisted reproduction. The health declaration should include questions about the general state of health of the couple or woman. It shall also include questions about circumstances, events and behaviors which may present a risk of contagion or disease which may be transmitted to the child-to-be, such as travel habits, geographical origin, long stay in another country, injection abuse, accidents, vaccinations and the intake of medicinal products, and medical and non-medical interventions.**

Woman's name	Social security number
Partners Name	Social security number
Address	Phone numbers you can be reached at
ZIP code	City
Marital Status      Single <input type="checkbox"/> Has Partner <input type="checkbox"/>	
Current occupation/occupation:	Height: ..... cm Weight: ..... kg
Where were you born (country)?	Geographical origin (where did you originate from?) :
Do you smoke?      No <input type="checkbox"/> Yes <input type="checkbox"/> Number of cigarettes/day:	
Do you sniff?      No <input type="checkbox"/> Yes <input type="checkbox"/> Number of doses/week:	
Do you drink alcohol?      No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, how much alcohol do you drink/week? .....	
Strong liquor (cl) ..... Wine (cl) ..... Beer (cl) .....	
Have you ever injected narcotics/drugs?      No <input type="checkbox"/> yes <input type="checkbox"/>	
Are there possible hereditary diseases in your immediate family – or is there a disease that many in your family have? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, which ones?	
<b>Do you have or have you had other illnesses (which prompted hospitalization or check-up visits)?</b>	
Blood clot      No <input type="checkbox"/> Yes <input type="checkbox"/>	Abdominal or gynecological surgery      No <input type="checkbox"/> Yes <input type="checkbox"/>
Bleeding propensity      No <input type="checkbox"/> Yes <input type="checkbox"/>	Gynecological disease      No <input type="checkbox"/> Yes <input type="checkbox"/>
Heart or lung disease      No <input type="checkbox"/> Yes <input type="checkbox"/>	Kidney disease      No <input type="checkbox"/> Yes <input type="checkbox"/>
Jaundice (hepatitis)      No <input type="checkbox"/> Yes <input type="checkbox"/>	Depression (medically treated)      No <input type="checkbox"/> Yes <input type="checkbox"/>
Diabetes      No <input type="checkbox"/> Yes <input type="checkbox"/>	Thyroid Disease (Metabolism)      No <input type="checkbox"/> Yes <input type="checkbox"/>
What's your menstrual cycle like? <input type="checkbox"/> Regular, number of days from the start of the period to the next start of the period..... <input type="checkbox"/> Irregular: .....	
Last period? .....	
Have you used ovulation tests?	How did the test work out?      positive <input type="checkbox"/> negative <input type="checkbox"/>
Are you taking medications?	No <input type="checkbox"/> Yes <input type="checkbox"/> which?

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Do you have any drug allergies? No <input type="checkbox"/> yes <input type="checkbox"/> against what?		
Are you vaccinated against Rubella? No <input type="checkbox"/> Yes <input type="checkbox"/> hepatitis B? No <input type="checkbox"/> yes <input type="checkbox"/>		
Have you been vaccinated in the last 6 months? No <input type="checkbox"/> Yes <input type="checkbox"/> Which vaccine?		
When was the last Pap smear?		Are you treated for cell changes (cervix conization), when?
Do you have or have you had genital diseases or genital problems? No <input type="checkbox"/> Yes <input type="checkbox"/> which?		
Have you had any surgery? No <input type="checkbox"/> Yes <input type="checkbox"/> which/which?		
Have you had an accident that has required hospitalization? No <input type="checkbox"/> Yes <input type="checkbox"/> . If yes, when and what?		
How long have you wished to have children?		
Have you previously undergone any childlessness investigation, hormone or IVF treatment? No <input type="checkbox"/> yes <input type="checkbox"/>		
If yes, when and which clinic?	When?	Number of times
Have you ever been pregnant? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, Child <input type="checkbox"/> Miscarriage <input type="checkbox"/> Abortion <input type="checkbox"/>		
Do you have children? No <input type="checkbox"/> yes <input type="checkbox"/>		
If yes, number of children?	Years born?	Was your delivery normal?
Have you undergone medical/non-medical procedures in the last 6 months? No <input type="checkbox"/> yes <input type="checkbox"/>		
<b>Do you have during the last three months</b> (Enter comment, e.g. when, where) stayed abroad for more than three weeks straight? No <input type="checkbox"/> yes <input type="checkbox"/> .....		
had contact with medical care abroad? No <input type="checkbox"/> Yes <input type="checkbox"/> for what reason?.....		
<b>Risk behavior</b>		
Anabolic steroids or drugs	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you been in a situation where there has been a risk of blood infection?	No <input type="checkbox"/>	yes <input type="checkbox"/>
Have you been in a situation where there has been a risk of sexually transmitted infection?	No <input type="checkbox"/>	yes <input type="checkbox"/>

<ul style="list-style-type: none"> <li>• <b>By my signature, I certify that:</b></li> <li>• The information I have provided is truthful.</li> <li>• I have had the opportunity to ask questions and received satisfactory answers.</li> <li>• I have understood that pre-existing infection and disease can be transmitted to the recipient (the person who will carry the pregnancy) and any children during fertility treatment.</li> </ul>
Date and Signature