Fertilitetscentrum
Stockholm

In preparation for the first visit at Fertilitetscentrum

(The woman)

Name: **Date of birth:**
Trying to become pregnant since:
Previous pregnancy: No ❑ Yes ❑ with present partner ❑ with a previous partner ❑
Deliveries (how many, when and where): No ❑ Yes ❑
Miscarriage or termination of pregnancy: No ❑ Yes ❑
Ectopic pregnancy: No ❑ Yes ❑
Menstrual periods: Interval (day from first day of menstruation until the next): Last period:
Previous gynaecological problems: Salpingitis No ❑ Yes ❑ Abnormal Papsmear No ❑ Yes ❑ Other:
Previous gynaecological checks: Pap smear No ❑ Yes ❑ Result: Breast examination No ❑ Yes ❑ Result:
Previous illnesses:
Medication taken regularly: No ❑ Yes ❑ Name of the medicine:
Allergies: No ❑ Yes ❑ Allergic to:
Do you smoke: No ❑ Yes ❑
Your weight (kg): **Your length (cm):**

Fertilitetscentrum
Storängsvägen 10
115 42 Stockholm