Health declaration

Name________________________Personal number ___________________Phone number_____________________

Lenght__________Weight__________

Have you had any of following;					
	Yes	No		Yes	No
Migraine with Aura			Cardiovascular disease		
Trombosis			Porphyria		
Epilepsy			Coagulation disorder		
Liver disease			Varicose vein		
Morbus Crohn			Melasma		
Ulcerative colitis			TBC		
Diabetes			Rheumatic diseases		
SLE			Breast cancer		
High blood preassure			Other; what:		

Have your mother/father/siblings had any of following;	**Yes**	**No**
Trombosis		
Dyslipidemias		
Heart attack or stroke (before the age of 55 for men)		
Heart attack or stroke (before the age of 65 for women)		

Are you using	**Yes**	**No**
Cigarettes		
Snus		
Vape		
Other nicotine products		

Menstruation

Your age when you got your first period: _______________

How many days are you bleeding on your period: ___________

How severe are your period pain between 1-10 (1 is nothing, 10 is really severe): _________

Menstrual cycle without contraceptive	**Mark**	**Menstrual flow**	**Mark**
<25 days		Light	
25-30 days		Normal	
31-35 days		Heavy	
>35 days			

Earlier used contraceptive	**Mark**
Birth control pills	
Mini pills	
Hormonal IUD	
Copper IUD	
Vaginal rings	
Birth control patches	
Injection	
Birth control implant	
Diaphragms	
Condom/other	

Pregnancys

Abortions, how many: _____________

Miscarriage: _____________________

Childbirths: ______________________