When you have filled in this form, please save it and send it to our secretaries via Secure mail.
Please find information about how to send it securely under 'Contact' on our website www.trianglen.com.

Information for fertility treatment

Thank you very much for contacting *Trianglen Fertility Clinic*. In order for us to provide the best possible treatment, we would like you to provide information about the cause of infertility and about your health in general.
You are also welcome to come to our clinic for a consultation.

You may also print the form and fill it out by hand. You may write in English or 'Scandinavian'.

Please fill out ***all fields (including blood tests) before returning this form***. If a male partner is not involved in the treatment, you may leave the 'male' fields blank.

*Please note that you must provide **printouts/PDF of blood tests for HIV and Hepatitis-B and -C** before treatment (page 3).*

*If you do not have a Danish 'Social Security Number', you must provide a **photocopy or PDF of your passport or official picture-ID**.*

Please fill out the form completely before you submit it.

Contact information

Woman's First name: ______________________ **Man's First name:** ______________________

Woman's Family name: ______________________ **Man's Family name:** ______________________

Woman's date of birth (dd/mm/yy): ______________ **Man's date of birth** (dd/mm/yy): ______________

Street address: ____

Town: ______________________ **Zip-code:** __________ **Country:** ______________________

Phone: ______________ **Mobile-phone:** ______________ **Email:** ______________________

Is the cause of infertility known?

If yes, please specify the cause

☐ No ☐ Yes ____

Type of treatment

If you know what type of treatment you will need, please indicate it

☐ Intrauterine insemination with male partner's semen
☐ Intrauterine insemination with semen from a sperm donor
☐ IVF (In Vitro Fertilisation)
☐ ICSI (In vitro fertilisation with micro insemination (ICSI - IntraCytoplasmic Sperm Injection))
☐ Oocyte donation
☐ Other, please specify: ____
☐ We/I would like *Trianglen Fertility Clinic* to evaluate our/my case and provide advice

Previous fertility treatment

If yes, please provide as much information about previous treatment as possible. Please send copies of treatment details.

☐ No ☐ Yes ______________________________

____

____

____

____

Information about the woman

Height (cm): __________ **Weight** (kg): __________ **Alcohol** units per *week*: __________ **Cigarettes** per *day*: __________

Have you ever been pregnant?

If yes, please provide brief information about the previous pregnancies

☐ No ☐ Yes Deliveries: ______ Miscarriages: ______ Induced abortions: ______

____

____

Have you ever experienced allergic reactions against any type of medicine?

If yes, please specify the type of medicine and the type of reaction

☐ No ☐ Yes ______________________________

____

Do you take any medicine daily?

If yes, please specify the type of medicine, the dose and the reason why you use it

☐ No ☐ Yes ______________________________

____

Do you suffer from any kind of disease?

If yes, please specify the type of disease

☐ No ☐ Yes ______________________________

____

Menstrual cycle - do you have a regular menstrual cycle?

If the interval between your menstrual bleedings is between 26-32 days, please indicate 'Yes'. Otherwise, please indicate 'No' and specify the interval

☐ Yes ☐ No ______________________________

Fallopian tubes - has the passage through the Fallopian tubes been assessed?

If yes, please specify
The passage may be assessed by X-ray (HSG: HysteroSalpingoGraphy), by laparoscopy or by ultrasound (hysterosalpingo-contrast-ultrasonography)

☐ No ☐ Yes ______________________________

Have you ever had pelvic inflammatory disease (PID) or genital infection with *chlamydia*?

If yes, please specify

☐ No ☐ Yes ______________________________

Tests for HIV, hepatitis-B and hepatitis-C (within the past 12 months) - MUST BE PROVIDED

Please indicate the results of tests for HIV, hepatitis-B and heptitis-C. You ***must provide printouts*** of the laboratory results

HIV-1,2: ☐ Negative ☐ Positive   **HBs Ag:** ☐ Negative ☐ Positive

HCV Ab: ☐ Negative ☐ Positive   **HBc Ab:** ☐ Negative ☐ Positive

Blood tests for hormone levels (within the past 12 months) and other tests

Please provide information about the following blood tests (**Please note that FSH, LH and estradiol should be measured on cycle day 2 or 3**)

AMH (Anti-Mullerian Hormone), if available. Please also indicate the unit of measurement: ______________________

FSH: ______ **LH:** ______ **Estradiol** (please include unit of measurement (pg/mL, pmol/L): ______________________

TSH: ______ **Prolactin:** __________ Laboratory's **reference interval** for prolactin: ______________________

Rubella (German measles) test**:** ☐ Positive ☐ Negative *If negative, please discuss vaccination with your doctor*

PAP-smear (within 2 years): ☐ Normal ☐ Not normal/done *If not normal or not done, please consult your doctor*

Chlamydia test (within 6 months): ☐ Normal ☐ Not done *If not done, please consult your doctor*

Information about the man (may be omitted if a male partner is not involved)

Height (cm): __________ **Weight** (kg): __________ **Alcohol** units per *week*: ________ **Cigarettes** per *day*: ______

Has the sperm quality been assessed?

If yes, please describe the results

☐ No ☐ Yes ____

____

If the sperm quality is reduced, is the reason known (e.g. vasectomy, chemotherapy etc.)?

If yes, please specify

☐ No ☐ Yes ____

____

Tests for HIV, hepatitis-B and hepatitis-C (within the past 12 months) - MUST BE PROVIDED

Please indicate the results of tests for HIV, hepatitis-B and heptitis-C. You ***must provide printouts*** of the laboratory results

HIV 1,2: ☐ Negative ☐ Positive   **HBs Ag:** ☐ Negative ☐ Positive

HCV Ab: ☐ Negative ☐ Positive   **HBc Ab:** ☐ Negative ☐ Positive

Comments

Please provide any additional comments here

____

____

____

____

Date (dd/mm/yy): ______________________