Date of visit Year Month Day

Women's Medical Questionnaire

***Please fill out this form accurately.**

(You)	Name (Family, Given)	Date of birth Year Month Day (age:) Occupation :
	Cell phone number	E-mail address on your cell phone
(Partner)	Name (Family, Given)	Date of birth Year Month Day (age:) Occupation :
	Cell phone number	E-mail address on your cell phone
Address	(Zip code)	Home phone E-mail address

***We use your personal information for administrative purposes only.**
***Would you mind if we mention the name of our clinic when we contact you on the phone? (Yes・No)**
***Have you attended our clinic's seminar? (Attended/ Year Month , Not attended)**

1 **Blood Type** A・B・O・AB RH(+)・(−) **Height** cm **Weight** kg **BMI** kg/m^2

2 **Specific treatment you would like.**
Medical evaluation ・Fertility check ・ Male infertility treatment ・ IUI ・
IVF-ET other ( )

3 **Marital status** Age at marriage _____years old (Date: Year_____Month_____Day_____)
Divorce (Year Month) Second Marriage (Year Month)
Engaged ・ Common-law marriage ・ Single

4 **Length of sterility** (_____years_____months)

5 **Has the cause of your infertility been diagnosed?**
(Diagnosis :)

6 **Last three menstrual cycles**
Started from ___month/___date Length of bleeding: for _____ days
Started from ___month/___date Length of bleeding: for _____ days
Started from ___month/___date Length of bleeding: for _____ days
Age of first menstruation _____years old **Length of cycle**_____days (regular・irregular)、
Bleeding for _____days **Amount** (Heavy・Moderate・Light) **Menstrual disorder** (Yes・No)

7 **Have you ever been pregnant? (Yes・No)**
If yes, give the details.
Abortion (_____times) Date:(Y.M.D) ____/__/____ ____/__/____
Miscarriage (_____times) Date:(Y.M.D) ____/__/____ ____/__/____
Ectopic pregnancy (_____times) Date:(Y.M.D) ____/__/____ ____/__/____
Delivery (_____times) Date:(Y.M.D)____/__/__ ____/__/____
└Natural childbirth (_____times) , Forceps delivery (_____times)
Vacuum extraction (_____times) , Caesarean delivery (_____times)

8 **Are you taking any medication or supplements regularly?** No・Yes (Name:

9 **Have you ever had any adverse reactions to a blood test, pelvic examination, injection, medicine, or treatment?** No・Yes (Details:)

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10 **Have you ever experienced any of the following ? If so, please give brief details.**

- **Any allergy :** No・Yes (　　)
- **Asthma :** No・Yes, in the past・Yes, currently (　　)
- **Glaucoma:** No・Yes (　　)
- **Diabetes:** No・Yes (　　)
- **High blood pressure:** No・Yes (　　)
- **Thrombosis (yourself) :**
  No・Yes, in the past・Yes, currently (　　)
- **Thrombosis (anyone in your family) :**
  No・Yes, in the past ・ Yes, currently (　　)

11 **Have you ever had a serious illness or undergone surgery? Please give the details from birth up until now, including current medical issues and past abnormal test results.**
No・Yes (details:　　)

12 **Have you ever had any infectious disease?**
No・Yes (hepatitis B・C, syphilis, AIDS, HIV, other (　　))

13 **Have you or anyone in your family ever had diagnosed with tuberculosis?**
No・Yes (who?　　)

14 **Does anyone in your family have sterility problems or any hereditary disease?**
No・Yes (who?　　)

15 **Do you smoke?** No・Yes (　　/ day) Started at the age of (　　)

16 **Do you drink alcohol?** No・Yes (Every day・ Sometimes)
Beer・Wine・Liquor (how much a day:　　)

17 **Intercourse** (about　　times a month)

18 **Other symptoms**
Abnormal lactation ・ coital pain ・ trembling of hands ・ drastic weight loss (　　kg)
Other (　　)

19 **Have you ever had a sexually transmitted disease such as chlamydia or gonorrhea?**
(No ・ Yes)

20 **Have you ever had the following fertility exams?**
① Basal body temperature (normal・abnormal) ② Hysterosalpingography (normal・abnormal)
③ Pertubation, Hydrotubation (normal・abnormal)
④ Semen examination (normal・abnormal: detail　　)
⑤ Laparoscopy (normal・abnormal)
⑥ Hormone examination (normal・abnormal)
⑦ Post-coital test (normal・abnormal) ⑧ Other (　　)

21 **Have you ever had the following fertility treatments? (previous clinic name:　　)**
① Timed intercourse (　　times) ② IUI (　　times)
③ Ovulation induction (Clomiphene:　　times, HMG:　　times)
④ Other medication (　　)
⑤ IVF ・ICSI (Oocyte pickup:　　times, Fresh embryo transfer　　times, Frozen-thawed embryo transfer　　times)
⑥ Other (　　)

22 **How did you learn about our clinic?** (Check the boxes below)
- ☐ Introduced by another doctor (Clinic:　　Doctor:　　)
- ☐ Introduced by someone (Name:　　Relationship:　　)
- ☐ Newspaper (Article about our clinic・Advertisement for our clinic)
- ☐ Public signboards
- ☐ Magazines (Akachan ga hoshii, Jineko, other :　　)
- ☐ Website (Searched by keywords・Site for fertility treatment・i-town page)
- ☐ Ninkatsu seminar (attended　saw the article)
- ☐ Other