Medical Questionnaire

Date: _____ (for official use) Chart #: _____ (for official use)

Name: first _____ middle _____ family _____
Date of birth: day _____ /month _____ / year _____ Age: _____
Nationality: _____
Address: _____
Phone #: (house) _____ (cell) _____ (work)_____
Occupation: _____ Office name: _____
E-mail address: _____@_____

Ⅰ What made you to visit this clinic? Choose number(s).

1. infertility
2. absence of menstruation
3. problem with menstruation
4. abnormal vaginal bleeding
5. vaginal discharge (pink, brown, yellow, or white)
6. vulvar itching or pain
7. abdominal pain
8. low back pain
9. lump (abdomen, genitals, or breast)
10. urinary frequency
11. pain during urination
12. Uterine/cervix cancer screening
13. STD test
14. others: _____

Ⅱ Menstrual history

1. When was your first period (age): _____
2. When did your last period begin? How long did you have bleeding? _____ (days)
3. Is your menstrual cycle regular (occurring every month)? Around how many days per cycle._____
   If irregular, around how many days per cycle? _____
4. Duration of your menstrual period _____ days
5. Amount of your menstrual bleeding heavy / normal / light
6. Do you have menstrual pain? Yes / No
7. Do you have any other problem during menstruation? Yes / No

Ⅲ Marital status and pregnancy history

1. Have you had sexual intercourse? Yes / No Age at first sexual contact
2. When did you get married? Year: Month:
3. Have you ever been pregnant? Yes / No
4. If you have been pregnant, have you had...
   a. artificial abortion? Yes (How many times? When?) / No
   b. miscarriage? Yes (How many times? When?) / No
   c. delivery? Yes (How many times? When?) / No

Ⅳ Current and past medical history

1. Have you had any medical illness or undergone surgery? Yes / No
2. If you had any medical illness or surgery, please answer the following questions:
   a. What kind of Medical Illness? How old were you?
      1. _____ Age: _____
      2. _____ Age: _____
   b. What kind of surgery? How old were you?
      1. _____ Age: _____
      2. _____ Age: _____
3. Have you had asthma? Yes / No
4. Have you received a blood transfusion? Yes / No
5. Have you had B or C type hepatitis test? Yes (Positive / Negative) / No
6. Are you under treatment or currently taking medicine?
   If so, please write down all the name of the medicine _____
7. Have you had side effects or allergic reaction to medicines or injections? Yes / No
   If so, please write down all the name of the medicine _____

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Ⅴ Is anybody in your family suffering from serious illness?
Yes (genetic disorder, high blood pressure, diabetes, cancer or others _____) / No

Ⅵ BASIC INFORMATION Height: cm Weight: kg Blood type: Rh(＋・－) A・B・O・AB

If you have taken infertility tests or treatment before, please continue the following questions.

Ⅰ Have you had hysterosalpingpgraphy (or hydrotubation test) ? Yes / No
The result was.....
Right: (Normal, obstructed, constricted, presence of adhesions, etc _____)
Left: (Normal, obstructed, constricted, presence of adhesions, etc _____)

Ⅱ Has your husband had sperm analysis? Yes / No
Was it normal or abnormal? Normal / Abnormal
If you have data, please fill out the result (If you have multiple data, please choose the best one.)
Date performed:_____ Semen volume: _____ ml Concentration: _____ million/ ml,
Motility: _____ % Abnormal Morphology: _____%

Ⅲ Have you had Postcoital test? Yes / No
The result was... Very good / Not so good / Bad

Ⅳ Have you had Timing method? Yes / No
If so, fill in the blanks below.
Natural cycle: ( ) times The last treatment day /month / year
Ovarian stimulated cycle: ( ) times The last treatment day /month / year

Ⅴ Have you had IUI (Intra-Uterine Insemination)?
If so, fill in the blanks below.
Natural cycle: ( ) times The last treatment day /month / year
Ovarian stimulated cycle: ( ) times The last treatment day /month / year

Ⅵ Have you had IVF?
If so, fill in the table below.

	Date of Oocycle retrieval	①conventional-IVF ②ICSI	Ovarian stimulation	HCG	# of Oocycle retrieval	# of fertilized embryos	①Blastcyst transfer ②Cleavade stage embryo transfer	# of transfered embryos	# of frozen embryos	Pregnancy
1	/ /									Y/ N
2	/ /									Y/ N
3	/ /									Y / N
4	/ /									Y / N
5	/ /									Y/ N

☆ Information about your husband
1. Name: first middle family
   Date of birth: day /month / year Age: _____
2. Occupation: _____
3. Is he healthy? Yes / No
4. Past medical history:

Thank you for your cooperation

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