Medical Questionnaire

Kato Ladies Clinic

Date: ______________________ (for official use)
Chart #: ___________________ (for official use)

Name: ______________________ Date of birth: _________________ Age: ________
Address: ____ Zip code: ____-____
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.atypical vaginal bleeding
5. discharge (pink, brown, yellow, or white) 6. vulval itching or pain
7. abdominal pain 8. low back pain 9. a lump (abdomen, genital, 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: y.o.
② When did your last period begin? How long did you have bleeding? For___days since____________
③ Is your menstrual cycle regular? Yes, around ________ days cycle/ No
④ Duration of your menstrual period around ________ days
⑤ Amount of your menstrual bleeding heavy / normal / slight
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
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 serious disease or undergone surgery? Yes / No
② If you had any serious disease or surgery, please answer the following questions:
a. What kind of disease? How old were you?
Disease name: Age: y.o.
Disease name: Age: y.o.
b. What kind of surgery? How old were you?
Name of surgery: Age: y.o.
Name of surgery: Age: y.o.
④ Have you had asthma? Yes / No
⑤ Have you received a blood transfusion? Yes / No
⑥ Have you had B or C type hepatitis test? Yes (Positive / Negative) / No
⑦ Are you under treatment or currently taking medicine?
If so, please write down all the name of the medicine ___________________________
⑧ 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 ___________________________

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, obstruct, constrict, adhesion, etc ________)
Left: (Normal, obstruct, constrict, adhesion, 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.)
Semen volume: _________ ml Concentration: _________ million/ ml, Motility: _______ %
Abnormality: _______%

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 ________/______/_________
Ovarian stimulated cycle: ( ) times The last treatment ________/______/________

Ⅴ Have you had IUI (Intra-Uterine Insemination)?

If so, fill in the blanks below.
Natural cycle: ( ) times The last treatment ________/______/_________
Ovarian stimulated cycle: ( ) times The last treatment ________/______/________

Ⅵ Have you had IVF?

If so, fill in the table below.

	Date of egg retrieval	① conventional-IVF ② ICSI	Ovarian stimulation	HCG	# of egg retrieval	# of fertilized embryos	① Blastocyst transfer ② Cleavade 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: ____________________________ Date of birth: ________________________ Age:
② Occupation: ____________________________
③ Is he healthy? Yes / No
④ Past medical history: __________________ __________________

Thank you for your cooperation

Name: ______________________________ Chart #: ________________________ (for official use only)