Questionnaire: Center for Human Reproduction and Gynecologic Endoscopy

Date: 20 yyyy/ mm/ dd

Name: ..... Age: ..... DOB: yyyy/ mm/ dd

Height: ..... cm Weight: ..... Kg Occupation: .....

Your emergency (mobile) #: .....

Your Partner's name: ..... Age: ..... Sanno ID#: .....

Your Partner's emergency (mobile)#: .....

1. What made you decide to visit our hospital? Please circle all that apply.

(1) Internet (choose 1 from a – e)
a. Advertising site b. our website c. YouTube d. TikTok e. Instagram f. X (formerly Twitter)
(2) Recommended from family, acquaintance, or friend (3) Referred from another medical institution
(4) Other (.....)

2. Have you ever had infertility testing/treatments at another facility?

☐ No / ☐ Yes (..... Hosp/Clinic) → **Bring Referral/test results, if any, on your initial visit.**

3. Purpose of visit Circle and describe as appropriate (mark all that apply)

(1) Actively trying for a baby for about: ..... year(s) and ..... month(s)
(2) I'd like to have infertility testing
(3) I'd like to have (Timing method / Artificial Insemination / IVF: In vitro fertilization cycle)
(4) I have difficulty having intercourse
(5) I have frozen egg(s) and I'd like to have Frozen embryo transfer (FET)
(6) Annual renewal of frozen (embryos / sperm) storage
(7) Other (.....)

4. Marital status Circle, check and/or describe as appropriate

Yourself: Married (..... at age) de facto marriage Planning to get married Single (Non virgin / Virgin)
Divorced → I have ☐ no child / ☐ ..... # child(ren) Other (.....)
Your partner: living (together/apart) Previous marriage (No/Yes) → ☐no child /☐ ..... # child(ren)

5. Menstrual history Circle and describe as appropriate

Age at first period .....
Menstrual cycle ..... - ..... days (Avg. ..... days) Regular / Irregular / ..... Other)
Bleeding usually lasts for ..... days Flow: (Heavy/Moderate/Light/Unsure)
Painful periods? No/Yes →Pain in the (Lower abdomen/Lower back/Head/..... Other)
Basal Body Temperature: Do you use a BBT chart? (No/Yes)→ Is it biphasic (low/high phases)? (Yes / No / Indistinct)
Last menstruation: from ..... mm/ ..... dd to ..... mm/ ..... dd (..... days)

6. Obstetric history Please fill in the following

#Total Pregnancies ..... #Total Deliveries ..... (→#Deliveries at/after 22weeks ..... #Stillbirths .....)
#Miscarriages ..... #Artificial Abortions .....
#Ectopic pregnancies ..... (Right tube/Left tube/ ..... Other /Unsure) #Hydatidiform moles .....

↑Pregnancies outside the uterus

Previous pregnancies in detail

(1) yyyy/ mm at age Natural pregnancy / Timing method / Artificial Insemination (AI) / IVF* or ICSI**
→ Vaginal Delivery / C-section / Miscarriage / Abortion / Other( )
Abnormality with Pregnancy / Delivery / Child(ren)→ No / Yes (Specify)

(2) yyyy/ mm at age Natural pregnancy / Timing method / Artificial Insemination (AI) / IVF* or ICSI**
→ Vaginal Delivery / C-section / Miscarriage / Abortion / Other( )
Abnormality with Pregnancy / Delivery / Child(ren)→ No / Yes(Specify)

(3) yyyy/ mm at age Natural pregnancy / Timing method / Artificial Insemination (AI) / IVF* or ICSI**
→ Vaginal Delivery / C-section / Miscarriage / Abortion / Other( )
Abnormality with Pregnancy / Delivery / Child(ren)→ No / Yes(Specify)

***IVF: In Vitro Fertilization, **ICSI: Intracytoplasmic sperm injection**

7. Infertility Tests, etc.

Have you ever tested with the following? (No/Yes)
→If Yes, check/circle, describe and bring test results for confirmation

☐ PAP smear: Normal / Abnormal (Specify) Last tested: yyyy/ mm/ dd

☐ Rubella Antibody (HI): titer Test date: yyyy/ mm/ dd
Childhood infection with Rubella (German measles) / Vaccination at age / Unsure

☐ Thyroid function: TSH: μIU/ml FT4: ng/dl FT3: pg/ml Test date: yyyy/ mm/ dd

☐ Infectious disease
HBs Ag: ( ) HCV Ab: ( ) Syphilis: (RPR ( ) / TPLA ( )) HIV: ( )

☐ Chlamydia Ab: IgA ( ) / IgG ( ) Test date: yyyy/ mm/ dd

☐ Anti-Mullerian hormone (AMH): choose unit(ng/ml / mol/L) Test date: yyyy/ mm/ dd

☐ The baseline female hormone test (given during your period)
LH: mIU/ml FSH: mIU/ml Estradiol: pg/ml Prolactin: ng/ml

☐ Hysterosalpingography or Hydrotubation Test date: yyyy/ mm/ dd
Normal / Abnormal (Specify)

☐ Postcoital (Huhner) test: Normal/Abnormal (Specify)Test date: yyyy/ mm/ dd

☐ Sperm immobilization Antibody: Negative / Positive Test date: yyyy/ mm/ dd

☐ Luteal function test Test date: yyyy/ mm/ dd
Estradiol: pg/ml Progesterone: ng/ml

☐ Test for Recurrent pregnancy loss Test date: yyyy/ mm/ dd
Normal / Abnormal (Specify)

☐ Semen Analysis Test date: yyyy/ mm/ dd
Normal / Abnormal (Specify)
→ Treatment/Surgery (No/Yes specify) in yyyy/ mm/ at Hosp

☐ Other test (Specify) date: yyyy/ mm/ dd
Test result ( )

8. Gynecological history Diagnosed or treated with the following? (No/Yes)
→If Yes, check/circle and describe

☐ Abnormal PAP smear (cervical cancer screening) result(s)
→(Visiting a doctor regularly / Had a surgery) at ..... Hospital
☐ Diagnosed with Myoma(Fibroid)/Endometriosis/ Ovarian cyst/Endometrial polyp/
Uterine adenomyosis/Chlamydia infection/ Other .....
And ・Had a surgery →(Operative method .....)in (yyyy/ mm) at (..... Hosp)
・Had (Name of treatment .....)
・Under observation/follow-up.
・Other .....

9. Infertility Treatment Have you ever had any infertility treatment? (No/Yes)
→If Yes, check/ describe and bring summary of treatment, if you have one

☐ Timing method (# .....)(yyyy/ mm/ - yyyy/ mm/) at (.....)Hosp./Clinic
☐ AI (# .....)(yyyy/ mm/ - yyyy/ mm/) at (.....)Hosp./Clinic
☐ IVF (# .....)(yyyy/ mm/ - yyyy/ mm/) at (.....)Hosp./Clinic
Egg retrieval:..... Fertilization method: #IVF ...../ #ICSI ...../ #Half IVF, half ICSI .....
#Fresh embryo transfer:..... #Frozen-thawed embryo transfer:.....

10. Previous IVF Treatment Please enter specific treatment details below.

Ovulation stimulation protocol
(A) Natural cycle (B) Clomid (Serophene) (C) Clomid – HMG (D) Antagonist
(E) Long protocol (F) Short protocol (G) Other:..... (H) Unsure

Egg retrieval/Fresh embryo transfer *Choose stimulation protocol from A-H above.

(1) yyyy/ mm Stimulation:(A-H) #Eggs retrieved:..... Fertilization: IVF/ICSI/Half & half
#Fertilized eggs:..... #Fresh ET:.....→Conceived (No / Yes) #Embryos frozen: .....
(2) yyyy/ mm Stimulation:(A-H) #Eggs retrieved:..... Fertilization: IVF/ICSI/Half & half
#Fertilized eggs:..... #Fresh ET:.....→Conceived (No / Yes) #Embryos frozen: .....
(3) yyyy/ mm Stimulation:(A-H) #Eggs retrieved:..... Fertilization: IVF/ICSI/Half & half
#Fertilized eggs:..... #Fresh ET:.....→Conceived (No / Yes) #Embryos frozen: .....
(4) yyyy/ mm Stimulation:(A-H) #Eggs retrieved:..... Fertilization: IVF/ICSI/Half & half
#Fertilized eggs:..... #Fresh ET:.....→Conceived (No / Yes) #Embryos frozen: .....

Frozen-thawed embryo transfer

(1) yyyy/ mm (Natural/HRT) #Embryos transferred:.....(Cleavage-stage/Blastocyst) →Conceived (No/Yes)
(2) yyyy/ mm (Natural/HRT) #Embryos transferred:.....(Cleavage-stage/Blastocyst) →Conceived (No/Yes)
(3) yyyy/ mm (Natural/HRT) #Embryos transferred:.....(Cleavage-stage/Blastocyst) →Conceived (No/Yes)
(4) yyyy/ mm (Natural/HRT) #Embryos transferred:.....(Cleavage-stage/Blastocyst) →Conceived (No/Yes)
(5) yyyy/ mm (Natural/HRT) #Embryos transferred:.....(Cleavage-stage/Blastocyst) →Conceived (No/Yes)

11. Past history other than Gynecology Check, circle and describe as appropriate

☐ Gastroenterology (Esophagus/Stomach/Bowel/Appendicitis) ☐ Respiratory (incl. Asthma)
☐ Cardiovascular (Heart/Blood Vessels) ☐ Liver/Gallbladder/Pancreas ☐ Kidney ☐ Hypertension
☐ Diabetes ☐ Thyroid ☐ Blood ☐ Rheumatoid/Collagen Disease ☐ Allergy ☐ Infectious Disease
☐ Urology ☐ Orthopedics ☐ Eye ☐ Skin ☐ Ear, Nose and Throat ☐ Neurosurgery ☐ Neurology
☐ Psychosomatic Med./Psychiatry ☐ Other .....

⇩Please fill in the details below

(1) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(Name .....)(Hosp)

(2) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(Name .....)(Hosp)

(3) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(Name .....)(Hosp)

12. Social history, Allergy, Asthma and Blood transfusion Check, circle and describe as appropriate

Use of Alcohol ☐ No ☐ Yes (Everyday / 2-3 times a week / Occasionally) ☐ Used to drink
Smoking ☐ No ☐ Yes (..... cigarettes/day for ..... years) ☐ Used to smoke

Drug Allergy ☐ No ☐ Yes → (Name .....)
Food Allergy ☐ No ☐ Yes → (Name .....)
Other Allergy ☐ No ☐ Yes → (Name .....)

Asthma ☐ No ☐ Yes → (Only in my childhood /No symptoms for now/Under treatment)
Last asthma attack in (yyyy/ mm)
Treated with (medicine .....) at (Hosp)

Blood transfusion ☐ No ☐ Yes → in (yyyy/ mm) at age ..... for (reason .....)

13. Family history If your blood family has/had any of the following, please check, circle and describe

☐ Father Hypertension/Diabetes/Cancer(Specify .....)
☐ Mother Hypertension/Diabetes/Cancer(Specify .....)
☐ Older/Younger Brother/Sister Hypertension/Diabetes/Cancer(Specify .....)
☐ Grandpa Hypertension/Diabetes/Cancer(Specify .....)
☐ Grandma Hypertension/Diabetes/Cancer(Specify .....)

Please feel free to write down any opinions/wishes you have regarding fertility tests/treatments or visits.

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Thank you for your cooperation. Please present this sheet at your consultation.