Questionnaire
Center for Reproduction and Gynecologic Endoscopy

Date: 20 yyyy/ mm/ dd

Name: Age: DOB: yyyy/ mm/ dd

Height: cm Weight: Kg Occupation:

Your emergency contact (mobile):

Husband/partner's Name: Age: Sanno ID#:

partner's/ Your husband's emergency contact (mobile)#:

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

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

2. 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 ( )

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

Yourself: Married (at age) de facto marriage Planning to get married Single (with partner)
Divorced → I have ☐ no child / ☐# child(ren) Other ( )

Your partner: lives (together/separately) Previous marriage (No/Yes) → ☐no child /☐# child(ren)

4. 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/Not sure)

Painful periods? No/Yes →Pain in the (Lower abdomen/Lower back/Head/Other)

Basal Body Temperature: Do you keep records? (No/Yes)→ Do you see low and high phases ? (Yes / No / Not sure)

Last menstruation: from mm/ dd to mm/ dd (days)

5. 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 /Unknown) #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**

6. 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 watchful waiting / follow-up.
- ・Other

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 / Unknown

☐ 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. 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:

9. 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) Unknown

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 No.4

(1) yyyy/ mm (Natural/HRT) #Embryos transferred: (The cleavage stage (deviding) Embryo /Blastocyst) →Conceived (No/Yes)

(2) yyyy/ mm (Natural/HRT) #Embryos transferred: (The cleavage stage (deviding) Embryo /Blastocyst) →Conceived (No/Yes)

(3) yyyy/ mm (Natural/HRT) #Embryos transferred: (The cleavage stage (deviding) Embryo /Blastocyst) →Conceived (No/Yes)

(4) yyyy/ mm (Natural/HRT) #Embryos transferred: (The cleavage stage (deviding) Embryo /Blastocyst) →Conceived (No/Yes)

(5) yyyy/ mm (Natural/HRT) #Embryos transferred: (The cleavage stage (deviding) Embryo /Blastocyst) →Conceived (No/Yes)

10. 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)

11. 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 .....)

12. 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 describe your comments and requests on infertility test/treatment or hospital visit freely.

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

Center for Reproduction and Gynecologic Endoscopy
Sanno Hospital