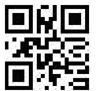
Fertility Questionnaire



Name:________________________________

Please☑the boxes or fill in the empty blanks to the items that apply to you.

1) How many years have you been trying to have kids? (The time period from when you first had the thought to conceive until now. This also includes times where perhaps you were not thinking about kids but you didn't use contraception either.)
挙児希望期間は何年位ですか？（妊娠を希望してから今までの期間。積極的に希望していなくても避妊していなかった期間も含みます。） ________years and _______months

2) Please tell us the details if you have had treatment up until now. 今まで治療されていれば内容を教えてください。

・Self-timing 自己タイミング About _______ months ☐I don't know the timing タイミングが分からない ☐Tendency of ED ED傾向
・Timing Treatment タイミング治療 _______ times tried ・AIH (Artificial Insemination using Husband's sperm) 人工授精 _______ times tried
・IVF (In Vitro Fertilization) 体外受精
OPU (oocyte pick-up) _____ times IVF _____ times ICSI (IntraCytoplasmic Sperm Injection "Micro-insemination") _____ times
(Short/Long Method _____times, Setrotide _____times, Clomid/Letrozole _____times)
ET (Embryo transfer) _____ times (Day 2・3 transfer _____times Day 4~7 transfer _____times)

3) Please fill in the boxes if you have the examination results. 今までの検査結果があればご記入ください。

Examination	Results	Date
Cervical Cancer Screening 子宮頸がん検診		_____ year _____ month
Chlamydia Test クラミジア検査		_____ year _____ month
Anti-sperm antibody 抗精子抗体		_____ year _____ month
AMH (Anti-Mullerian Hormone)		_____ year _____ month

Examination	Results	Date
LH		_____ year _____ month
FSH		_____ year _____ month
E2 (Estrogen Female Hormone)		_____ year _____ month
PRL (Prolactin)		_____ year _____ month

Hysterosalpingography Results 卵管造影結果	☐Normal ☐Problematic ( )
Huhner Test フーナーテスト	☐Normal ☐Problematic ( )
Semen Test 精液検査	☐Normal 異常なし ☐Problematic 異常あり ☐Low motility rate 運動率低い ☐Few sperm 数少ない ☐No sperm 精子がいない 精液量 Semen amount_________ 濃度 Concentration_________ 運動率 Motility rate_________ 奇形率 Malformation rate_________

4) Regarding your medical history and lifestyle habits. Have you ever been afflicted with the following illnesses?
既往歴、生活習慣についておききします。今まで以下の疾患にかかられたことがありますか？

Appendicitis 虫垂炎	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Chlamydia, Fallopian inflammation クラミジア感染症、卵管炎	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Endometriosis 子宮内膜症	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Uterine myomas 子宮筋腫	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Thyroid disease 甲状腺疾患	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Cervical dysplasia, Cervical cancer 子宮頚部異形成、子宮頸がん	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Ovarian cysts 卵巣嚢腫	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes
Endometrial polyps 子宮内膜ポリープ	☐No	☐Yes	Have surgery? 手術は？	☐No	☐Yes

Do you smoke? たばこは吸いますか？ ☐No ☐Yes
How much sleep do you get? 睡眠時間は？ ☐6~8 hours/night ☐Under 6 hours ☐Over 8 hours
Coffee, black tea and green tea intake? コーヒー、紅茶、緑茶は？ ☐Under 8 cups/day ☐Over or equal to 8 cups/day
Alcohol intake? アルコールは？ ☐2 glasses of wine; Under 500cc beer/week ☐More than the left amount ☐Other

5) About your husband ご主人様について

In furigana or Latin letters (as shown on passport) Name	TEL ( ) —	Height cm	Weight kg
		Blood Type ( )	Rh ( )
	Date of Birth _________ year ___________ month _____ day		Age
Nationality 国籍		Occupation 職業	

6) Please fill in the following information if you know it about your husband's medical history and medicine use.
ご主人の既往歴、内服薬をご存じでしたらご記入ください。

Adulthood mumps 成人後のおたふくかぜ ☐No ☐Yes ☐I don't know
Childhood groin hernia surgery 幼少時鼠径ヘルニア手術 ☐No ☐Yes ☐I don't know
Currently taking medication 薬を飲んでいる ☐No ☐Hair growth stimulant 増毛剤 ☐Gout medicine 痛風薬 ☐Diabetic medicine 糖尿病薬 ☐Antihypertensive 降圧剤
Does he smoke? たばこは吸いますか？ ☐No ☐Yes
How much sleep does he get? 睡眠時間は？ ☐6~8 hours/night ☐Under 6 hours ☐Over 8 hours
Coffee, black tea and green tea intake? コーヒー、紅茶、緑茶は？ ☐Under 8 cups/day ☐Over or equal to 8 cups/day
Alcohol intake? アルコールは？ ☐2 glasses of wine; Under 500cc beer/week ☐More than the left amount ☐Other