Obstetrical Questionnaire

Date_____________

（記載日）

Name_________________________Date of birth_________________Age________

（名前）　　　　　　　　　　　（誕生日）　　　　　　　　　　（年）

Address____

（住所）

Occupation_______________________

（職業）

Phone (house)______________________________(cell)_________________________

（自宅電話）　　　　　　　　（携帯）

E-mail____

What is wrong with you?　Circle one.

（どうなさいましたか？　まるをつけて下さい）

The treatment of infertility (Timing method, IUI, IVF, ICSI)

（不妊治療、ﾀｲﾐﾝｸﾞ療法、AIH、ICSI）

Irregular period

（生理不順）

Test for achieving pregnancy

（妊娠するかどうかのチェック）

others（　　　　　　　　　　　　　　　）

（その他）

Basic Information

（健康状態について）

Information about you（妻）

1 .Height：________/ft________/cm　　　Wight：________________kg

2. Do you smoke?　　　Yes　/　No（　　　/a day）

（たばこは吸いますか？）

3. Do you drink any alcohol?　　　Yes　/　No（　　　/a week）

（お酒は飲みますか？）

4. Do you drink coffee?　　　Yes /　No（　　　/a day）

（ｺｰﾋｰは飲みますか？）

5. Do you exercise?　　　Yes　/　No（　　　　　　　　　　）

（運動しますか？）

6 .If you are married,　when were you married？　Circle one.
（結婚していたら、いつしましたか？）　　　　　　　　　　（まるをつけてください）

Year:_____________Month:_____________

Engaged・common-law marriage・single・divorce（wife・husband）
(婚約中)　　　　　　　　　　　　（独身）　　　（離婚あり、　妻・　夫）

The age of divorce（　　　year's old）
（離婚した年齢）

7 .How long have you been having protected intercourse? (____year____month)
（避妊期間はどれくらいですか？）

8. How often do you have intercourse?　________times a month
（夫婦生活の回数）

9 Do you have any pain during intercourse?　　：　Yes　/　No

Information about your husband

1. Name__________________________　Date of birth__________________　Age__
2. Occupation__________________________
3. Height:________/ft_________/cm　　Weight:________________kg
4. Does he smoke?　　　　　　Yes　/　No（　　　/a day）
5. Does he drink any alcohol?　　Yes　/　No（　　　/a week）
6. Does he drink coffee?　　　　Yes　/　No（　　　/a day）
7. Does he exercise?　　　　　　Yes　/　No（　　　　　　　　）

Medical history

1 .Have you ever had a disease?
Yes (hypertension、diabetes, heart disease, kidney trouble, liver disease, asthma, fibroid, mental illness, venereal disease, others)/ No
　　Diseases name___________________________Age_______________y.o.

2 Have you ever had an operation?
Yes (ovary, fibroid, others)/No
　　Name of operation________________________Age________________y.o.

3 Has your husband ever had a disease?
Yes (hypertension、diabetes, heart disease, kidney trouble, liver disease, asthma, appendix, mental illness, mumps, epididymitis, others)/ No
　　Diseases name____________________________Age________________y.o.

4 Has your husband ever had an operation?

Yes (inguinal hernia, others)/No

Name of operation________________________Age________________y.o.

5 .Have or are you allergic to medication or food?　Yes　/　No

□medication　□food　□others________________________

6 Are you presently taking medication?　Yes　/　No

If so, please write down all the name of the medicine.__________________________

7 Is anybody in your family suffering from serious illness?

Yes (hypertension, diabetes, cancer________, others_______________________) / No

Menstrual history

1 When did your first period start?　Age__________y.o.

(初潮はいつですか？)

2 Are periods regular?　(生理は順調ですか？)　Yes　・　No

3 Do you have cramps?　(生理通はありますか？)　Yes　・　No

4 When did your recent period begin?　Since___________

(最近の生理はいつから始まりましたか？)

5 How long did you have bleeding?　For___days

(出血は何日間ありましたか？)

6 Intervals　________days

History of pregnancy　(妊娠歴)

Have you ever been pregnant?　Yes　・　No

(妊娠したことがありますか？)

□ Pregnancy　________times

□ Delivery　________times →　□ normal　________times

(出産)　□ abnormal ________times

□ Miscarriage　_________times →　□ natural abortion______times

□artificial abortion ______times

□ Others　□ ectopic pregnancy

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

1 、Which hospital did you have treatment before?

___________________ Hospital　year　month　～　year　month

2 、Have you had any treatments or tests?

Yes (hormone test、hysterosal pingography, sperm analysis, postcoital test,

Timing method, AIH, IVF, other) / No

Test □hormone test： date______/_______/______

□hysterosalpingography: normal / abnormal (right / left)

□postcoital test： very good / not so good / bad

□sperm analysis: normal / abnormal

□laparoscopic surgery

□hysteroscope

Treatment □used ovarian stimulation

□timing method ______times

□Intra – Uterine Insemination _______times

□IVF conventional-IVF ICSI

Egg retrieval ______times the last treatment___/___/___

Transferred embryos ______times the last treatment___/___/___

Frozen embryos _______times the last treatment___/___/___

If you have questions or something to ask, please write down.

Thank you for taking time to complete this Questionnaire.