

[About Infertility Treatment]

Examinations	Year /month	Abnormal
Hormone Test	/	yes · no
Hysterosalpingography	/	yes · no
Semen Analysis	/	yes · no
Others	/	yes · no

Treatment (Please circle the applicable items.)		
Timed Intercourse Guidance		
Ovulation Induction: None · Oral Medication · Injection		
Artificial Insemination	Times	
In Vitro Fertilization (IVF) / Intracytoplasmic Sperm Injection (ICSI) Hospital where Treatment was Performed ; (_____) (_____)	Egg Retrieval Times	Embryo Transfer Times

* If you have undergone in vitro fertilization (IVF) or intracytoplasmic sperm injection (ICSI), please bring any documents that show details of the stimulation methods, fertilization procedures, and treatment progress.

[Allergies] Please check and provide details if applicable.

Contrast agents	<input type="checkbox"/> No <input type="checkbox"/> No history <input type="checkbox"/> Yes (Drug : _____ Symptoms : _____)
Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes (Drug : _____ Symptoms : _____)
Food (e.g.,fruits)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Food : _____ Symptoms : _____)
Do you react (redness, itching) to alcohol-based disinfectants?	<input type="checkbox"/> No <input type="checkbox"/> Yes

[Health Checkups and Cancer Screenings]

General health check	<input type="checkbox"/> Within 1 Year <input type="checkbox"/> Scheduled <input type="checkbox"/> More than 1 Year Ago
Cervical cancer	<input type="checkbox"/> Within 1 Year <input type="checkbox"/> Scheduled <input type="checkbox"/> More than 1 Year Ago
Breast cancer	<input type="checkbox"/> Within 1 Year <input type="checkbox"/> Scheduled <input type="checkbox"/> More than 1 Year Ago
Dental checkup	<input type="checkbox"/> Within 1 Year <input type="checkbox"/> Scheduled <input type="checkbox"/> More than 1 Year Ago

[Medical History]

Past illnesses	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Current illnesses	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Asthma	<input type="checkbox"/> No <input type="checkbox"/> Yes (Medication: _____ Last attack: _____)
Current medications	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Surgery history	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Transfusion history	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Measles	<input type="checkbox"/> Had it <input type="checkbox"/> Antibodies present <input type="checkbox"/> Vaccinated <input type="checkbox"/> Scheduled <input type="checkbox"/> Unknown
Rubella	<input type="checkbox"/> Had it <input type="checkbox"/> Antibodies present <input type="checkbox"/> Vaccinated <input type="checkbox"/> Scheduled <input type="checkbox"/> Unknown

[Lifestyle]

Meals per day	times/day Nutrition balance: <input type="checkbox"/> Poor <input type="checkbox"/> Generally good
Snacks	<input type="checkbox"/> No <input type="checkbox"/> Yes (times/day: Content:)
Sleep	hours/day Quality: <input type="checkbox"/> Good <input type="checkbox"/> Poor (Details:)
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes (times/week: Type:)
Alcohol consumption	<input type="checkbox"/> No <input type="checkbox"/> Yes (glasses/day: times/week: Type:)
Smoking (incl.e-cig)	<input type="checkbox"/> No <input type="checkbox"/> Yes (cigarettes/day: years: Type:)
Constipation	<input type="checkbox"/> No <input type="checkbox"/> Yes (Treatment:)
Herbal medicines/supplements	<input type="checkbox"/> No <input type="checkbox"/> Yes ()
Support during hospitalization, pregnancy, postpartum	<input type="checkbox"/> No <input type="checkbox"/> Yes ()
Religious considerations (transfusion, diet, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes ()
Family members requiring nursing care	<input type="checkbox"/> No <input type="checkbox"/> Yes ()

Thank you for completing this form. Please bring it with you at your appointment.

☆ Medical Questionnaire ☆ (Male)

Please fill in the following items. This information will be used only for the purpose of gathering medical information.

Patient ID Number	Date of Birth
Name	Mobile Phone Number
Occupation (_____) Work Schedule (Working Hours and Other Details) Day Shift Includes Night Shift Irregular Schedule Flexible Working Hours Available Can you adjust your work schedule for hospital visits? Possible · Not Possible	Height _____ cm (Your weight will be measured at the time of your visit.) Married: Year Month · Not legally registered First Marriage · Remarriage

【About Infertility Treatment】 (If your wife has filled out this questionnaire, you don't need to fill it out again.)

Semen Analysis	Year month Abnormal no · yes	Treatment : Varicocele Surgery year month Oral Medication (_____) Other (_____)
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【Allergies】 Please check and provide details if applicable.

Drugs	<input type="checkbox"/> No <input type="checkbox"/> Yes (Drug : _____ Symptoms : _____)
Food (e.g.,fruits)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Food : _____ Symptoms : _____)
Do you react (redness, itching) to alcohol-based disinfectants?	<input type="checkbox"/> No <input type="checkbox"/> Yes

【Medical History】

Past illnesses	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Current illnesses	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Current medications	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Surgery history	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Transfusion history	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
Hair growth products	<input type="checkbox"/> No <input type="checkbox"/> Yes (_____)
General health check	<input type="checkbox"/> Within 1 Year <input type="checkbox"/> Scheduled <input type="checkbox"/> More than 1 Year Ago
Measles	<input type="checkbox"/> Had it <input type="checkbox"/> Antibodies present <input type="checkbox"/> Vaccinated <input type="checkbox"/> Scheduled <input type="checkbox"/> Unknown
Rubella	<input type="checkbox"/> Had it <input type="checkbox"/> Antibodies present <input type="checkbox"/> Vaccinated <input type="checkbox"/> Scheduled <input type="checkbox"/> Unknown

【Lifestyle】

Meals per day	times/day Nutrition balance: <input type="checkbox"/> Poor <input type="checkbox"/> Generally good
Snacks	<input type="checkbox"/> No <input type="checkbox"/> Yes (times/day Content: _____)
Sleep	hours/day Quality: <input type="checkbox"/> Good <input type="checkbox"/> Poor (Details: _____)
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes (times/week Type: _____)

Alcohol consumption	<input type="checkbox"/> No <input type="checkbox"/> Yes (glasses/day times/week Type:)
Smoking (incl.e-cig)	<input type="checkbox"/> No <input type="checkbox"/> Yes (cigarettes/day× years Type:)
Herbal medicines/supplements	<input type="checkbox"/> No <input type="checkbox"/> Yes ()
Religious considerations (transfusion, diet, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes ()
Family members requiring nursing care	<input type="checkbox"/> No <input type="checkbox"/> Yes ()

Partner(wife) name

Date of Birth