**Basic Questionnaire(For women)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Name | Age | Birthday | Blood type | Occupation | Marital status | Nationality | E mail |
| 1 | Patient |  |  |  |  |  |  |  |  |
| 2 | Husband |  |  |  |  |  |  |  |  |
| 3 | Year of Marriage( ) Legally Registered? : □Yes □No  ***Proof of legal marriage is required in IUI and IVF (a copy of marriage license and/or family registry)*** | | | | | | | | |
| 4 | How long have you tried to get pregnant with unprotected sex? ( )Years ( )Months | | | | | | | | |
| 5 | Have you ever been pregnant? □No □Yes  If yes, describe(include miscarriages, abortions, and ectopics) Pregnant( ) Children( )   |  |  |  |  | | --- | --- | --- | --- | | Year | Method of Delivery | Miscarriage / Abortion | Current Age of Child | |  |  |  |  | |  |  |  |  | | | | | | | | | |
| 6 | Menarche( ) First (starting) day of last period ( )  Menstrual history: □ regular □ irregular  Interval: □ 22-24days □ 25-27days □28-30days □30-35days □Irregular  Duration: □2-4days □4-5days □5-7days □more than 7days □Other days  Dysmenorrhea: □None □Mild □Severe | | | | | | | | |
| 7 | Have you ever done a PAP Smear? □No □Yes(Last exam date : Year □Normal □Abnormal) | | | | | | | | |
| 8 | Type of contraception: | | | | | | | | |
| 9 | Have you ever had any infertility tests? □No □Yes  If yes, please indicate which ones and their results.  Hormone Test( ) HSG / Fallopian Tube Exam( ) Hysteroscopy( ) | | | | | | | | |
| 10 | Has your husband ever had a Semen Analysis? □No □Yes  (Results : □Normal □Abnormal ) | | | | | | | | |
| 11 | Have you received any Infertility Treatments/Procedures? □ No □ Yes   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Methods | # of Times | Hospital | Methods | # of Times | Hospital | | Tracking Ovulation |  |  | IUI |  |  | | Hormone Medication |  |  | IVF |  |  | | | | | | | | | |
| 12 | Do you have any medical condition (diabetes, hypertension, thyroid, etc)? □No □Yes  If yes, describe | | | | | | | | |
| 13 | Are you currently taking any medication? □No □Yes(List )  Are you allergic to any type of medication? If yes, list. | | | | | | | | |
| 14 | Have you ever had any surgeries? □No □Yes(Type of surgery: ) | | | | | | | | |
| 15 | Anyone in the family have any medical condition (diabetes, hypertension, thyroid, etc)?  □No □Yes If yes, describe( ) | | | | | | | | |
| 16 | Do you drink or smoke? □ Yes □ No  If yes, how many packs a day? ( ) How many years have you been smoking? ( )  How many times do you drink per week? ( ) How many years have you been drinking? ( ) | | | | | | | | |
| 17 | What would you like to get done at CHA Medical Center?  □Exams    □Tracking Ovulation    □IUI   □IVF   □Surgery    □Undecided | | | | | | | | |
| 18 | How did you hear about our hospital?  □ Referred by friend □ Internet  □ Media (newspaper, magazine, etc) □ Already knew about CHA Fertility Center, Seoul station  □ Employee of Hospital □ Other( ) | | | | | | | | |