|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | **Patient** | Birth of date | Nationality | | Occupation | Height | Blood type: | | Weight | Blood Pressure: |
| #BIRTH\_DAY\_10 |  | |  |  |  | |  |  |
| 2 | **Husband** | Name | Age | Nationality | | Occupation | | Blood type: | | Birth of date |
|  |  |  | |  | |  | |  |
| 3 | Marital status?  : □Single □Married □Divorced □Remarried □Widowed □Other ( ) | | | | | | | | | |
| 4 | 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)* | | | | | | | | | |
| 5 | First (starting) day of last period : ( )  Cycle: □ 25-27days □28-30days □31-35days □Irregular  Period duration: □2-3days □4-5days □6-7days □more than 8days □Other days  Dysmenorrhea (Cramping/pain during period): □None □Mild □Severe  Recent changes in the amount of period: □No □Yes ( ) | | | | | | | | | |
| 6 | How long have you tried to get pregnant with unprotected sex? Years Months | | | | | | | | | |
| 7 | 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 | |  |  |  |  | |  |  |  |  | | | | | | | | | | |
| 8 | Have you ever had any infertility tests? □No □Yes  If yes, please indicate which ones and their results.  Hormone Test: ( ) Blood Test: ( ) Hysteroscopy: ( )  HSG / Fallopian Tube Exam: ( ) Other: ( ) | | | | | | | | | |
| 9 | Has your husband ever had a Semen Analysis? □No □Yes  (Results : □Normal □Abnormal ( ) | | | | | | | | | |
| 10 | Have you ever done a PAP Smear? □No □Yes(Last exam date : Year Month) | | | | | | | | | |
| 11 | Have you ever had any surgeries? □No □Yes(Type of surgery: ) | | | | | | | | | |
| 12 | Do you have any medical condition (diabetes, hypertension, thyroid, etc)? □No □Yes  If yes, describe( )  Anyone in the family have any medical condition (diabetes, hypertension, thyroid, etc)? □No □Yes  If yes, describe( ) | | | | | | | | | |
| 13 | Are you currently taking any medication? □No □Yes(List ) | | | | | | | | | |
| 14 | Are you allergic to anything? □No □Yes(List : ) | | | | | | | | | |
| 15 | Have you received any Infertility Treatments/Procedures? □ No □ Yes   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Methods | # of Times | Hospital | Methods | # of Times | Hospital | | Tracking Ovulation |  |  | IUI |  |  | | Hormone Medication |  |  | IVF |  |  | | | | | | | | | | |
| 16 | Partner's Physician Name ( ) Partner's Patient ID Number ( ) | | | | | | | | | |
| 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( ) | | | | | | | | | |