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| 1. | **Wife** | Name: | Age: | Date of birth: | | Nationality: |
| 2. | 생년월일: #BIRTH\_DAY\_10 | | | Contraception method: | | Nationality: |
| 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. | What evaluation / procedure is your partner currently receiving at our hospital?  □ Tests/Evaluations □ Estimation of Ovulation Date □ IVF □ IUI □ Surgery | | | | | |
| 6. | Do you need to freeze your sperm today (due to traveling abroad, business trip, etc)? □ Yes □ No | | | | | |
| 7. | Have you ever had a Semen Analysis? □ Yes □ No  If yes, Date ( ), Hospital ( ), # of Times ( )  Results: □ Normal □ Low Sperm Count □ Low Motility □ Abnormal Shape | | | | | |
| 8. | Have you ever had any infertility tests? □ Yes □ No  If yes, please indicate which ones and their results.  Hormone Test ( ) Chromosome Analysis ( ) Ultrasound ( ) Other ( ) | | | | | |
| 9. | When did you last ejaculate? ( days ago) | | | | | |
| 10. | Has your partner ever been pregnant? □ Yes □ No  If yes, describe (include miscarriages, abortions, and ectopics)  # of Times Pregnant ( ) Current # of Children ( )   |  |  |  |  | | --- | --- | --- | --- | | Year | Method of Delivery | Miscarriage / Abortion | Current Age of Child | |  |  |  |  | |  |  |  |  | | | | | | |
| 11. | Have you received any Infertility Treatments/Procedures? □ Yes □ No   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Methods | # of Times | Hospital | Methods | #of Times | Hospital | | Tracking ovulation |  |  | IUI |  |  | | Hormone Medication |  |  | IVF |  |  | | | | | | |
| 12. | Partner’s Physician Name ( ) Partner’s Patient ID Number ( ) | | | | | |
| 13. | 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? ( ) Tolerance (# of bottles) (beer(s) ) (soju ) | | | | | |
| 14. | Do you take hot baths, use hot tubs, or go to saunas? □ Yes □ No | | | | | |
| 15. | Have you ever had any surgeries? □ Yes □ No If yes, what type of surgery?  Do you have any medical conditions (diabetes, hypertension, thyroid, etc)? □ Yes □ No  If yes, describe. | | | | | |
| 16. | Are you currently taking any medicines on a regular basis? □ Yes □ No If yes, list.  Are you allergic to any type of medication? If yes, list. | | | | | |
| 17. | How many siblings do you have?  # of Brothers ( ) # of Sisters ( ) | | | | | |
| 18. | How did you hear about our hospital?  □ Referred by friend  □ Media (newspaper, magazine, etc)  □ Employee of Hospital □ Internet  □ Already knew about CHA Gangnam Medical Center  □ Other( ) | | | | **Consent**  I, Consent that my spouse,  Will be informed about my fertility Exam results  Date of Birth:  Name: Signature: | |