# INITIAL CONSULTATION QUESTIONNAIRE

*Page 1 | Please also complete the reverse side.*

**Date: _____ / _____ / 20____**
(Month / Day / Year)

**FERTILITY CLINIC TOKYO**

*** Note:** If your partner has already visited our clinic prior to today, please inform the reception desk.

## 1. Desired Examinations & Treatments (Check all that apply)

**☐ Fertility Consultation:**

☐ Starting with Initial Testing ☐ Timed Intercourse (Timing Method) ☐ Intrauterine Insemination (IUI)
☐ In Vitro Fertilization (IVF) ☐ Recurrent Pregnancy Loss Testing/Treatment 不育 ☐ Falloposcopy 卵管鏡
☐ Psychological Counseling 心理 ☐ Genetic Counseling 遺伝 ☐ Second Opinion

**☐ Egg Freezing (Oocyte Cryopreservation)** **☐ Hysterosalpingography (HSG) Only**

**☐ Other:** _____

## 2. Contact Information

** Please write clearly and accurately, as the clinic may contact you by phone.*

### Female Patient Information

| | |
|---|---|
| **Full Name:** | **Tel:** _____ |
| **Date of Birth:** _____ / _____ / _____ (M/D/Y) (Age: ) | **Occupation:** _____ |
| **Address:** Postal Code: _____ | |

### Male Partner Information (if applicable)

| | |
|---|---|
| **Full Name:** | **Tel:** _____ |
| **Date of Birth:** _____ / _____ / _____ (M/D/Y) (Age: ) | **Occupation:** _____ |
| **Address:** Postal Code: _____ | |

## 3. Recent Menstrual & Gynecological History

| | |
|---|---|
| **Menstrual Cycle:** ____ to ____ days (☐ Regular / ☐ Irregular) | ☐ Amenorrhea (No menstruation)無月経 |
| **Last Menstrual Period (Start Date):** ____ / ____ / 20____ (M/D/Y) | **Currently taking birth control pills?** ☐ No / ☐ Yes |
| **History of sexual intercourse or pelvic (internal) gynecological examination?** ☐ No / ☐ Yes 性交・内診経験 | |
| **Rubella Antibody Test:** ☐ No / ☐ Yes (When: _____ )風疹抗体 | **Currently taking folic acid?** ☐ No / ☐ Yes 葉酸 |
| **Pregnancy History:** Pregnancies: ____ 妊娠 Live Births: ____ 出産 Miscarriages: ____ 流産 Induced Abortions: ____中絶 | |

## 4. Medical History & Allergies

**Allergies:** ☐ None ☐ Yes
(Details:_____)アレルギー

**Asthma:** ☐ None ☐ Yes 喘息

**Thyroid Disease:**
☐ None ☐ Yes (Details:_____ )甲状腺

**Past / Current Medical Treatments:**
☐ None ☐ Yes ( Details: _____)治療歴

**Surgical History:**
☐ None ☐ Yes ( Details: _____)手術歴

## 5. Fertility History, Previous Treatments & Testing

**Duration of Infertility:** ☐ Less than 1 year ☐ 1 to less than 2 years ☐ 2 years or more

**Difficulties with Intercourse:** ☐ None ☐ Yes (☐ Pain during intercourse 性交痛 / ☐ Difficulty scheduling intercourse 日程調整困難 ☐ Erectile or ejaculatory dysfunction 勃起不全・射精困難 / ☐ Other: _____ )

**Previous Fertility Treatments:**

☐ Never received treatment ☐ Timed Intercourse (Timing Method) ☐ Intrauterine Insemination (IUI)

☐ In Vitro Fertilization (IVF): 【Self-pay: Egg retrieval ____ times / Embryo transfer ____ times】

【Insurance: Egg retrieval ____ times / Embryo transfer ____ times】

**Previous Fertility Tests Performed (Check all that apply):**

☐ Never been tested ☐ Basal Body Temperature (BBT) ☐ Menstrual Phase Hormone Blood Test

☐ Luteal Phase Hormone Blood Test ☐ AMH ☐ Thyroid Blood Test ☐ Huhner (Postcoital) Test

☐ Hysterosalpingography (HSG) ☐ Hysteroscopy ☐ Laparoscopy ☐ Antisperm Antibody Test

☐ Chlamydia Test ☐ Recurrent Pregnancy Loss Testing ☐ Semen Analysis ☐ Other: _____

## 6. Marital Status & History

**Current Marital Status:** ☐ Married ☐ Common-law / De facto marriage ☐ Unmarried / Single

**Divorce History (Female):** ☐ None ☐ Yes 妻 離婚歴

- Previous Marriage 1: Age ____ to ____ Children: ☐ None / ☐ Yes ( ____ child/children)
- Previous Marriage 2: Age ____ to ____ Children: ☐ None / ☐ Yes ( ____ child/children)

**Divorce History (Male Partner):** ☐ None ☐ Yes 夫 離婚歴

- Previous Marriage: Age ____ to ____ Children: ☐ None / ☐ Yes ( ____ child/children)

## 7. Lifestyle Habits

**Female Patient:**

Height: _____ cm / Weight: _____ kg General Health: ☐ Good ☐ Poor

Past Smoking: ☐ None ☐ Yes (From age ____ ) Current Smoking: ☐ None ☐ Yes (Approx. ____ cigarettes/day)

Alcohol Consumption: ☐ None ☐ Yes (Approx. _____ ml/day Type: _____ )

**Male Partner:**

Height: _____ cm / Weight: _____ kg General Health: ☐ Good ☐ Poor

Past Smoking: ☐ None ☐ Yes (From age ____ ) Current Smoking: ☐ None ☐ Yes (Approx. ____ cigarettes/day)

Alcohol Consumption: ☐ None ☐ Yes (Approx. _____ ml/day Type: _____ )

## 8. Referral Information & Female Doctor

**Referral Source (Please fill in if applicable, to the best of your knowledge):**

☐ Referred by Physician (Clinic/Hospital: _____ / Dr.: _____ Referral Letter: ☐ Yes / ☐ No)

☐ Referred by Acquaintance (Referrer's Name: _____ )

**Female Doctor Request 女医希望**

Female Dr.requested for the following reasons only. If you need, please check one.

☐Religious reasons 宗教 ☐No previous sexual experisnce 性交経験なし

## 9. Notice & Guidelines for All Clinic Visitors

Our clinic strives to maintain a safe and comfortable environment where all patients can receive treatment with peace of mind.

**[Rules to Observe]**

- Compliance with clinic rules (including the policy prohibiting bringing children to appointments)
- Prohibition of verbal abuse, intimidation, or loud, coercive behavior toward medical staff
- Prohibition of any behavior that disturbs the peace or invades the privacy of other patients

**If any violation of the above rules is confirmed, the clinic reserves the right to refuse consultation or ask you to leave the premises**

**Signature (Female /Handwritten ) :**

**Signature (Male / Handwritten) :**