ＩＤ：＿＿＿＿＿＿＿＿

Required item

フリガナ　　Month Day Year

Name(wife)＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿（Age　）Date of Birth　　/　　/

Occupation＿＿＿＿＿＿ Nationality＿＿＿＿＿＿＿＿Weight＿＿＿＿kg /Height＿＿＿＿cm

Mobile phone＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

Address 〒＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

フリガナ　　Month Day Year

Name(Husband)＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿（Age　）Date of Birth　　/　　/

Occupation＿＿＿＿＿＿ Nationality＿＿＿＿＿＿＿＿Weight＿＿＿＿kg /Height＿＿＿＿cm

Mobile phone＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿

What is your preferred treatment plan？

□Infertility tests　□Timing method　□IUI　□IVF/ICSI　□Second opinion

□Repeated miscarriage tests　□Egg Freezing　□Others　(　　)

Month　Day　Year

**Last period　From　　/　　/　　**

・Past surgery【□No/□Yes 】 illness【□No/□Yes】

□surgery : Details＿＿＿＿＿＿＿＿ age ＿＿＿＿, Details＿＿＿＿＿＿＿＿ age ＿＿＿

□illness : Details＿＿＿＿＿＿＿＿ age ＿＿＿＿, Details＿＿＿＿＿＿＿＿ age ＿＿＿

・Past infertility tests □Blood tests □Hunner test □Hysterosalpingography □Semen Analysis

・Past infertility treatments　□Timing method　□Ovulation induction

□Artificial insemination　□IVF/ICSI

・Smoking history □No □Yes(→Now continue □Yes:　cigarettes per 1 day / □No)

・Blood transfusion □No/□Yes

・Allergy of Medicines/foods □No/□Yes : Details of allergens＿＿＿＿＿＿＿＿

・Have you ever been pregnant?【□No/□Yes 】

Number of pregnancies □0、□1、□2、□3、□4、＿

Number of deliveries □0、□1、□2、□3、□4（Abnormality at delivery □No/□Yes）

Number of preterm deliveries □0、□1、□2、□3、□4

Number of miscarriages□0、□1、□2、□3、□4

Marriage □Formal /□Common-law marriage /□Single（If you wish to freeze eggs, please fill out the following）→ Emergency Contact Name＿＿＿＿＿＿＿＿

Relationships　　/Pnone＿＿＿＿＿＿＿＿

Have you had sexual intercourse? □No（Usually transvaginal ultrasound by a male doctor, but rectal ultrasound by a female doctor is an option） / □Yes