INITIAL CONSULTATION – EGG FREEZING

MEDICAL QUESTIONNAIRE

Date: _____ / _____ / _____

1. REQUESTED TESTS / TREATMENT

☐ Egg freezing（卵子凍結）

☐ Other:（その他） _____

2. CONTACT INFORMATION

Patient Information（患者情報）

Name (in full)	
Telephone	
Date of birth (YYYY / MM / DD)	_____ / _____ / _____ Age（ ）
Occupation	
Address	

Emergency Contact Information (緊急時)

Name	
Telephone (Domestic Only)	
Relationship to you	

3. MENSTRUAL HISTORY（生理周期）

Menstrual cycle	_____ to _____ days
Cycle pattern	☐ Regular ☐ Irregular ☐ Amenorrhea (no menstruation)
First day of your most recent period	_____ / _____ / _____ (YYYY / MM / DD)
Are you currently taking birth control pills?	☐ No ☐ Yes
Have you ever had sexual intercourse or a gynecological examination (pelvic examination)?	☐ No ☐ Yes

4. PREGNANCY HISTORY（妊娠歴）

Number of pregnancies: _____ Number of deliveries: _____ Number of miscarriages: _____

Number of induced abortions: _____

5. MARITAL STATUS（婚姻状況）

☐ Married ☐ Common-law marriage / De facto marriage ☐ Unmarried / Single

6. MEDICAL HISTORY AND ALLERGIES（既往歴・アレルギー）

Allergies	☐ No ☐ Yes If yes, please specify: _____
Asthma	☐ No ☐ Yes
Thyroid disease	☐ No ☐ Yes Details: _____
Medical treatment history	☐ None ☐ Yes Details: _____

Surgical history	☐ None ☐ Yes Details: _____

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7. PREVIOUS MEDICAL TESTS（過去受けた検査）

Please check all that apply. ☐ I have not undergone any of the following tests.

☐ Basal body temperature charting ☐ Hormone blood tests during period ☐ Hormone blood tests during the luteal phase

☐ AMH (Anti-Müllerian Hormone) test ☐ Thyroid function blood test ☐ Postcoital test (PCT / Huhner test)

☐ Hysterosalpingography (HSG) ☐ Hysteroscopy ☐ Laparoscopy ☐ Antisperm antibody test ☐ Chlamydia test

☐ Recurrent pregnancy loss testing ☐ Other:_____

8. LIFESTYLE（生活習慣）

Height / Weight	Height: _____ cm Weight: _____ kg
General health	☐ Good ☐ Poor
Past smoking history	☐ No ☐ Yes — Started at age: _____
Current smoking	☐ No ☐ Yes — Approximately _____ cigarettes per day
Alcohol consumption	☐ No ☐ Yes — Approximately _____ mL per day

9. REFERRAL INFORMATION（紹介者）

If you were referred to our clinic, please provide the following information, if known.

☐ Referred by my attending physician

Medical institution: _____ Physician: _____

Referral letter: ☐ Yes ☐ No

☐ Referred by an acquaintance

Name of the person who referred you: _____

10. FEMALE DOCTOR REQUEST（女医希望）

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

☐ Religious reasons ☐ No previous sexual experisnce

11. IMPORTANT NOTICE TO ALL PATIENTS

Our clinic is committed to providing a safe and comfortable environment in which all patients can receive medical care with peace of mind.

Please observe the following clinic rules:

- Please comply with all clinic rules (including the policy that children are not permitted to accompany patients during visits).
- Verbal abuse, intimidation, or loud and aggressive behavior toward medical staff is prohibited.
- Any behavior that disturbs the peace or infringes on the privacy of other patients is prohibited.

If any violation of the above rules is observed, the clinic reserves the right to refuse consultation or ask the patient to leave the premises, at the clinic's discretion.

I have read and understood the above notice.

Patient's Name (please print): _____

Patient's Signature (please sign by hand): _____

Date: _____ / _____ / _____