※Only authorized medical staff of Acupuncture Clinic for Women Shiryo have access to this interview sheet.

Acupuncture Clinic for Women Shiryo　interviewsheet

Date：Year/　　　　Month/　　　　Date/

First Name		Last Name		DOB MM/DD/YY	
Address	〒			TEL	
Height	cm	Weight	kg	BMI	

Please mark the answer with a circle.

1．When did you get married?

Half a year ago / A year ago / A year and a half ago / Two years go / About three years ago
About four years ago / About five years ago / More than five years ago (_____ years ago).

2．Questions about menstrual and its symptoms:

①How old were you when you started having menstrual periods? Age ___
②My menstrual periods are… Regular / Irregular
③My usual length of menstrual cycle is ____ days
④Duration of bleedings _____days
⑤First date of last menstrual cycle __/___/___(month/day/year)
⑥Duration of bleedings in last menstruation _____days
⑦My menstrual flow is usually… Heavy / Normal / Light
⑧Do you experience clotting? Yes / No
⑨Do you have painful periods? Yes / No
⑩Do you experience any breast tenderness before periods? Yes / No

3．Questions about vaginal discharge (Please answer only when you have symptoms concerned.)

①Do you experience a vaginal discharge in your preovulatory phase? Yes / No

②If you have experienced different color of vaginal discharge before, what color was it?
White yogurt-like / Yellow / Green / Pustule-like / Brownish-red

③If you have experienced different symptoms of vaginal discharge before, what was it?
White yogurt-like / Yellow / Green / Pustule-like / Brownish-red

④If you have experienced different symptoms of vaginal discharge before, what was it?
Waterly / Smelling / Painful / Itching

4. Questions about pregnancy history:

①Have you ever used birth control? (From year month) (For years months)
②How long have you desired your pregnancy? (For years months)
③Have many pregnancy have you had? (Number)

5. Questions about last pregnancy:

(When you chose "yes" to the question no.5③, please answer the following questions.)

Number of pregnancy	Birth year	Pregnancy course	Infant sex / Birth weight	The name of your maternity hospital
1	Year/ Month/	☐ Type delivery (vaginal delivery / cesarean delivery) ☐ Abortion(weeks) ☐Stillbirth(weeks) ☐ Miscarriage (a positive reaction / a fetal sac / fetal heartb (weeks) ☐ Ectopic pregnancy(weeks)	M・F / Unknown weeks g	
2	Year/ Month/	☐ Type delivery (vaginal delivery / cesarean delivery) ☐ Abortion(weeks) ☐Stillbirth(weeks) ☐ Miscarriage (a positive reaction / a fetal sac / fetal heartb (weeks) ☐ Ectopic pregnancy(weeks)	M・F / Unknown weeks g	
3	Year/ Month/	☐ Type delivery (vaginal delivery / cesarean delivery) ☐ Abortion(weeks) ☐Stillbirth(weeks) ☐ Miscarriage (a positive reaction / a fetal sac / fetal heartb (weeks) ☐ Ectopic pregnancy(weeks)	M・F / Unknown weeks g	

6. Do you work?

No / Yes Working hours (from ______ to ______) (Full-time / Part-time Line of work:______________)

7. Have you ever experienced any infertility tests? If yes, please fill out the following form.

★ Blood-drawing

	Inspection item	Outcome	Date of implementation	Menstrual cycle	The clinic name	Comments
★	FSH	mIU	Year_____ Month_____	Day ______		
★	LH	mIU	Year_____ Month_____	Day ______		
★	estrogen / E2	pg	Year_____ Month_____	Day ______		
★	Progesterone / P4	pg	Year_____ Month_____	Day ______		
★	Prolactin	mIU	Year_____ Month_____	Day ______		
★	AMH	ng/pmol	Year_____ Month_____	—		
★	CAI25	U	Year_____ Month_____	—		
★	Thyroid function	Normal Abnormal	Year_____ Month_____	—		
★	Habitual abortion test	Normal Abnormal	Year_____ Month_____	—		
★	Antisperm antibody	— ・ +	Year_____ Month_____	—		
★	Chlamydia	— ・ +	Year_____ Month_____	—		
Laparoscope / Uteroscope				—		

8. Questions about infertility tests:

①Have you ever experienced hysterosalpingography test or hydrotubation te Yes / No

If yes, please explain.

Right: (Normal / Obstruction / Narrowing / Adhesion / Hydrosalpinx / Everything else)

left: (Normal / Obstruction / Narrowing / Adhesion / Hydrosalpinx / Everything else)

②Has your husband ever experienced sperm testing? Yes / No

If yes, please answer the following questions.

Amount of seminal fluid: __________ml Concentration: _________ ten thousand / ml

Sperm mobility: ________ % Spermatozoon malformation rate: ___________ %

③Have you ever experienced Huehner test or postcoital test? Yes / No

If yes, please write about the best test results.

(Good / Semi-poor / Poor / others( ))

④Have you ever experienced the timing method? Yes / No

If yes, please answer the following questions.

Total experienced number of the timing method in a natural period (number____)

The last date of the timing method: (Year____ Month_____ Day_____)

Total experienced number of the timing method in an ovarian stimulation period (number____)

The last date of the timing method: (Year____ Month_____ Day_____)

⑤Have you ever experienced AI? Yes / No

If yes, please answer the following questions.

Total experienced number of the timing method in a natural period (number____)

The last date of the timing method: (Year____ Month_____ Day_____)

Total experienced number of the timing method in an ovarian stimulation period (number____)

The last date of the timing method: (Year____ Month_____ Day_____)

⑥Have you ever experienced IVF? Yes / No

If yes, please fill out the following chart.

With respect to A Ovarian stimulation, B Fertilization technique and C Implant procedure,
please choose the right answer from the following words.(Please fill out to the best of your knowledge.)

A :	【A1】Natural period 【A２】 Only Clomiphen or Serophen 【A3】 hMG / rFSH (plus Clomiphen)
B :	【B1】 Conventional IVF 【B２】Microinsemination(ICSI) 【B3】Rescue ICSI
C :	【C1】 IVF in a natural ovulatory cycle 【C２】 Transplantation in a low stimulus period
	【C3】Transplantation in a period taken hormone adjustment / replacement

● Egg-retrieval

	Date	A Ovarian stimulation	Whether hcg is used or not	Number of eggs	Number of fertilized eggs	Number of blastocysts	Number of implantable blastocysts	B Fertilization technique	The clinic name
example	Year_____ Month___	A3		five	four	three	three	B1	
1									
2									
3									
4									
5									

● Embryo transfer

※Stimulation Endometrium Embryo Tran

	Date	C Transfer technique	Number of transplant embryo	Fresh embryo Frozen embryo	Assisted hatching	SEET※	HCG level after embryo transfer	Pregnancy status	The clinic name
example	Year_____ Month____	C1	one	fresh / frozen	No / Yes	No / Yes	10.3ng	No / Yes	
1									
2									
3									
4									
5									
6									
7									
8									
9									

9．Questions about major disease, operation and condition:

①Have you ever experienced any major diseases or operatior Yes / No

If yes, please explain.

● Disease

High blood pressure (age) Diabetes (age) Heart disease (age)
Liber ailment (age) Kidney disease (age) Asthma (age)
Thyroid deficiency (age) Tuberculosis (age) Mental illness (age)
others ( )

● Operation

Ovary (age) Uterine fibroid (age) Ectopic pregnancy (age) Appendix (age)
Cesarean operation (age) others (

②Do you smoke?

I have smoked _______ cigarette per day since I was _______ years old.

③Do you drink alcohol?

I drink _______ ml of _________ per __________.

④Are you presently taking medication?

Yes( ) / No

１０．Will you tell me how you found our clinic?

①In a magazine ( )
②Internet ( )
③By a friend ( )
④Others ( )