

MEDICAL QUESTIONNAIRE (FEMALE)

INSTRUCTIONS: Write legibly in black letters and check ☒ the appropriate box where applicable



CONCEIVE
IVF MANILA INC.

PATIENT INFORMATION									
FIRST NAME			MIDDLE NAME			SURNAME			
DATE OF BIRTH (MM/DD/YYYY)		SEX MALE FEMALE		CIVIL STATUS		NATIONALITY			
PARTNER'S FIRST NAME			PARTNER'S MIDDLE NAME			PARTNER'S SURNAME			
RESIDENTIAL ADDRESS (Brgy./Subd./Street)									
CITY		ZIP CODE		PROVINCE		COUNTRY			
EMAIL ADDRESS			OCCUPATION			COMPANY			
MOBILE NUMBER				TAX IDENTIFICATION NUMBER (TIN)					
CLIENT SOURCE (How did you know about our clinic?) WEBSITE FB PAGE FAMILY/FRIENDS PREVIOUS/EXISTING PATIENT OB REFERRAL OTHERS: _____									
REFERRED BY				AFFILIATED HOSPITAL/CLINIC (OPTIONAL)					
BASIC INFORMATION									
HEIGHT IN CM			WEIGHT IN KG			BLOOD TYPE			
REASON FOR VISIT									
Infertility years: _____ <div> <div> Problem with menstruation Abnormal vaginal bleeding Vulvar itching or pain Vaginal discharge Pink Yellow Brown White </div> <div> Abdominal pain Low back pain Urinary frequency Pain during urination Uterine cervix cancer screening </div> <div> Lump Abdomen Genital Breast Sexually transmitted infection Others: _____ </div> </div>									
MENSTRUAL HISTORY									
Age of first menstrual period: _____					Amount of menstrual bleeding: Light Normal Heavy				
Start date of last menstrual period: _____ Duration: _____					Menstrual pain: YES NO				
Menstrual cycle: Regular Irregular Days of interval of menses: _____					Other problems during menstruation: YES NO				
MARITAL STATUS AND PREGNANCY HISTORY									
Have you had sexual intercourse? YES NO					Date of marriage: _____				
Have you ever been pregnant? YES NO					Delivery Frequency: _____ Date: _____ Miscarriage Frequency: _____ Date: _____ Artificial abortion Frequency: _____ Date: _____				
CURRENT AND PAST MEDICAL HISTORY									
Have you had any serious disease or undergone surgery? if YES, Disease/Surgery: _____ Year: _____					Have you had side effects or allergic reactions to medicines or injections? YES NO if YES, Name of medicine or injection: _____				
Have you had asthma? YES NO					Is anybody in your family suffering from a serious illness? YES NO Genetic disorder Cancer Diabetes Others: _____ High blood pressure				
Have you received a blood transfusion? YES NO									
Have you had a B or C type of hepatitis test? YES NO Hepatitis B: Positive Negative Hepatitis C: Positive Negative									
Are you currently under treatment or taking medicine? if YES, Treatment or Medicine? _____					Have you taken any infertility tests or treatment before? YES NO				

Refer to the back page

INFERTILITY TEST AND TREATMENT HISTORY

Have you had hysterosalpingography or hydrotubation test?

YES NO

if YES, Right:

Normal Obstruct Constrict Adhesion Others

Left:

Normal Obstruct Constrict Adhesion Others

Has your husband had sperm analysis?

YES NO

if YES, NORMAL ABNORMAL

RESULT SEMEN VOLUME: _____ml

ABNORMALITY: _____%

CONCENTRATION: _____million/ml

MOTILITY: _____%

Have you had a timing method?

YES NO

Natural

Frequency: _____

Date of last treatment: _____

Ovarian Stimulated

Frequency: _____

Date of last treatment: _____

Have you had IUI (intra-uterine insemination)?

YES NO

Natural

Frequency: _____

Date of last treatment: _____

Ovarian Stimulated

Frequency: _____

Date of last treatment: _____

Have you had a post-coital test?

YES NO

Very Good Not So Good Bad

Have you had IVF?

YES NO

PATIENT CONSENT FORM

In relation to the Data Privacy Act of 2012, I understand and give my consent to Conceive IVF Manila Inc. (CIMI) to process my Personal Data which may include its collection, recording, retrieval, use, retention, and disposal/destruction.

The Personal Data that I will provide may include my full name, birthdate, address, nationality, sex, religious affiliation, contact information, medical information, medication, medical history, and other information which may be relevant to or necessary for the purpose of the healthcare services (collectively Personal Data) I am availing from CIMI, which includes procedure(s), treatment (s), diagnosis, and or other related healthcare services, as well as relevant business processes like payment processing.

I understand that CIMI itself will process the Personal Data that I will be providing, but it may also disclose my Personal Data to:

- c) third parties who provide products and services to CIMI in relation to the healthcare services that CIMI provides; and
- d) other third parties (such as, but not limited to, Department of Health, Philippine Health Insurance Corporation, my employer or my insurance provider), where required or permitted by law or contract, including regulatory authorities/government agencies.

I also understand that CIMI will:

- c) collect and process the Personal Data of my next of kin/legal representative which I provided them and I warrant that I obtained their consent prior to providing their personal data to CIMI prior to or in the course of availing of CIMI's healthcare services; and
- d) share said personal data to third parties that provide products and services to CIMI in relation the healthcare services I am availing from CIMI.

I am aware and I agree that Personal Data I will provide will be retained by CIMI as prescribed by the law, rules, and regulations, or as long as necessary for the purpose of maintaining my medical records. I understand that CIMI will retain my Personal Data while the healthcare services I have sought from it are being rendered and for ten (10) years from the date of termination of our service agreement, in view of the 10-year prescriptive period for claims arising from written contracts. I am aware that it is my right to correct/update my personal data with CIMI, limit its use, or to withdraw the consent I am giving in this document by writing to CIMI at: dataprivacy@conceive.ph

By withdrawing my consent, CIMI will no longer have to provide further healthcare services to me. CIMI will also delete my Personal Data to the fullest extent that it is allowed by pertinent medical laws, rules, and regulations.

I am placing my signature below as proof that I was given the chance to read and understand CIMI's Data Privacy Policy and I am also aware that CIMI may revise its Data Privacy Policy and I can ask to be informed of the same. I can contact them using the contact details provided above, or any new address of CIMI, as may subsequently be announced on its website or given through any other mode of giving written notice.

By signing this medical questionnaire, I hereby give my consent to Conceive IVF Manila Inc. to use my photo, palm vein biometric and Personal Data for the production of my Conceive IVF Manila Inc. Patient Identification (ID) Card.

(Patient's Signature above printed name)
(Thumbmark if unable to sign)

Date (MM / DD / YYYY)

Time