

## MEDICAL QUESTIONNAIRE (MALE)

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 <input type="checkbox"/> MALE <input type="checkbox"/> 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?) <input type="checkbox"/> WEBSITE <input type="checkbox"/> FB PAGE <input type="checkbox"/> FAMILY/FRIENDS <input type="checkbox"/> PREVIOUS/EXISTING PATIENT <input type="checkbox"/> OB REFERRAL <input type="checkbox"/> OTHERS: _____					
REFERRED BY		AFFILIATED HOSPITAL/CLINIC (OPTIONAL)			

### BASIC INFORMATION

HEIGHT IN CM	WEIGHT IN KG	BLOOD TYPE
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### FERTILITY HISTORY

Have you experienced infertility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	DURATION: _____
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### PAST MEDICAL HISTORY

History of medical disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, Diabetes      Chronic Respiratory Tract Disease Hypertension      Fibrocystic Disease of the Pancreas Cancer      Neurologic Disease Tuberculosis      Others: _____
History of medical treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO	REMARKS: _____
High fever in the past six (6) months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	REMARKS: _____
History of surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, Urethral Structures      Bladder Neck Operation Hypospadias      Vasectomy Prostatectomy      Hydrocelectomy Inguinal Hernia      Others: _____ Sympathectomy
History of urinary infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
History of sexually transmitted disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, Syphilis      Gonorrhea Chlamydia      Others: _____
History of epididymitis?	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, LEFT      RIGHT
History of pathology possibly causing testicular damage:	<input type="checkbox"/> YES <input type="checkbox"/> NO	if YES, Orchitis      LEFT      RIGHT Injury      LEFT      RIGHT Torsion      LEFT      RIGHT

Refer to the back page

History of varicocele treatment?	YES	NO	Date of treatment: _____ LEFT      RIGHT
History of testicular maldescent?	YES	NO	if YES, LEFT      RIGHT
Treatment of testicular maldescent?	YES	NO	Age of treatment: _____ Type:              MEDICAL              SURGICAL

### 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:

- a) third parties who provide products and services to CIMI in relation to the healthcare services that CIMI provides; and
- b) 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:

- a) 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
- b) 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](mailto: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