For women

St. Mother Hospital

Name		Date of Birth		
Address				
Telephone Number		Emergency Contact #	Cell	
			Home	
Mail Address				
Occupation				
Date of Marriage		Start of Menstruation-Age		

1	Is your menstrual cycle regular?		
2	How many days did your last cycle last?		
3	Dates of last menstrual cycle		
4	Have you ever been pregnant?		
5	If yes, please explain in detail such information	Age of children	
		Vaginal delivery or C-section	
		History of miscarriage, stillbirth, or abortion	
6	Childbirth History (Please write if you have experienced any problems during childbirth)		
7	Are you recording your Basal Body Temperature(BBT)		
8	Do you have any health problems currently? If yes, please explain.		
9	Have you ever had a hysterosalpingography? If there were abnormal findings, please write here in deta?	No Yes →	
10	Have you ever experienced any abnormal side effects due to medication or shots, such as itching, rash, heart palpitations, shock, etc?		
11	Are you allergic to any medications?		
12	Have you ever contracted any of the following diseases? Hepatitis B Hepatitis C STD AIDS or HIV Leukemia None		
13	Have you ever been diagnosed with any of the following conditions? Cancer Diabetes Asthma Heart Disease High Blood Pressure Stroke None		
14	Have you ever had a blood transfusion?		
15	If you have ever had a major illness or operation, please explain in detail here.		
16	Have you ever undergone fertility treatment? If yes, please explain.		