OBSTETRICS and GYNECOLOGY

産婦人科問診票

カルテ NO.＿＿＿＿＿＿

Check(✔)all corresponding answers.　　年　月　日

First name **Family name** **Date of birth: year month day**

Address: **Phone:**

E-mail address:

Do you have Japanese health insurance? ☐ **Yes** ☐ **No**

Do you have private health insurance? ☐ **Yes** ☐ **No**

Nationality: **Language:**

What did bring you today?

☐Pregnancy (Estimated Date of Delivery? ＿＿Year＿＿month＿＿day)

☐Irregular period 月経異常 ☐Vaginal discharge おりもの ☐Abdominal pain 腹痛 ☐Polyp ポリープ

☐Irregular genital bleeding 不正性器出血 ☐Ovarian cyst 卵巣のう腫 ☐Vaginal itching 性器のかゆみ

☐Uterine fibroid 子宮筋腫 ☐kidney/bladder/urinary infection/Cystitis 膀胱炎 ☐Infertility 不妊症

☐STD check 性感染症検査 ☐Others(　　)

Menstrual history

＊When did your first period start？ 初潮はいつですか？ Age＿＿years

＊When was your menopause？ 閉経はいつですか？ Age＿＿years

＊Are your periods normally regular？ 月経は順調ですか？ ☐ Yes ☐ No

＊Intervals 周期について ☐28days ☐30days ☐＿＿days ☐ irregular

＊Periods 持続期間 last＿＿days

＊Menstrual flow 月経量 ☐ heavy ☐ normal ☐light

＊Do you suffer from pain during period? 月経痛 ☐ Yes (☐heavy ☐moderate ☐light) ☐ No

＊Date of your last period. 最終月経はいつですか ＿＿month＿＿day

History of pregnancy

☐ Pregnancy ＿＿times

☐ Delivery ＿＿times → ☐ Vaginal ＿＿times ☐ C-section ＿＿times

☐ Miscarriage＿＿times → ☐ natural miscarriage＿＿times ☐ D&C＿＿times

☐ Abortion ＿＿times ☐ Others → ☐ Ectopic pregnancy ☐ Hydatidiform mole

Do you want to deliver your baby? ☐ Yes ☐ No

Have you ever been allergic to medication or food? ☐No

☐ Yes →☐medication＿＿＿＿＿＿ ☐food＿＿＿＿ ☐others＿＿＿＿

Are you currently taking medication? ☐ No

☐ Yes → ＿＿＿＿＿＿ If you have any with you now, please show them to us

Have you ever had a pap smear? ☐ No ☐ Yes → the most recent＿＿year＿＿month＿＿day

What illnesses have you had in the past?

☐stomach and intestinal disorder ☐liver disease ☐heart disease ☐kidney disease ☐tuberculosis

☐high blood pressure ☐diabetes ☐asthma ☐AIDS ☐thyroid problem ☐STD ☐others＿＿＿＿

Have you ever had any operations other than Caesarean Section? ☐ No ☐ Yes →＿＿＿＿

Have you ever had a blood transfusion? ☐ No ☐ Yes

Family's medical history : Fill out family's age and tick(✓)any diseases they had

	age	healthy	not healthy	hereditary disease	high blood pressure	diabetes	cancer
father		☐	☐	☐	☐	☐	☐
mother		☐	☐	☐	☐	☐	☐
brothers		☐	☐	☐	☐	☐	☐
sisters		☐	☐	☐	☐	☐	☐
husband		☐	☐	☐	☐	☐	☐
children		☐	☐	☐	☐	☐	☐