

Hospital ID No. _____

Questionnaire

Date : _____ / _____ / _____

Name _____ (age _____) Nationality _____
 Occupation _____ Height _____ cm Weight _____ kg (Normal weight before pregnancy)

【 1 】 Purpose of your visit (Please mark ✓ to applicable items)

- Pap smear Vaginal discharge Itchiness Lower abdominal pain
- Abnormal vaginal bleeding Menstrual disorder Menopause
- Uterine fibroid Infertility Others (_____)
- Diagnosis of pregnancy (Please mark ○ to applicable items)

Those who examined themselves with commercially available test agents ⇒ [positive • negative] Date of decision (/ /)
Referral patients from other hospitals ⇒ Letter of reference [Yes • No] Expected delivery date (/ /)
Not examined



In case of pregnancy [hope to deliver • not decided • abortion request]
If you hope to deliver, please mark ○ one of these : Place to deliver [our hospital • another hospital (_____) • not decided]
How did you get pregnant this time? [natural • infertility treatment]
Have you been examined for uterine cancer (cervical region) within 1 year? No • Yes (when? _____) ⇒ result : [positive • negative]

【 2 】 Menstrual History

- ① First menstruation [age _____] ② Menopause [age _____]
- ③ Intervals [regular • irregular] ⇒ _____ ~ _____ days ④ Periods _____ days
- ⑤ Menstrual flow [heavy • normal • light] ⑥ Menstrual pain [Yes • No]
If yes, ⇒ [Lower abdominal pain • Low back pain • others] medicine to use [_____]
- ⑦ Last menstrual period [from _____ / _____ / _____ ~ _____ days]
Second menstruation from last time period [from _____ / _____ / _____ ~ _____ days]

【 3 】 Marriage • Family (Please mark ○ to applicable items)

- ① [Married • Single] If married, ⇒ when? (your age) _____ Husband's age(actual) : _____
- ② Is there anyone who has a blood relationship and has had any of following diseases? [Yes • No]
Please fill in the relationship with you in (_____).
Diabetes (_____) High blood pressure (_____) Thrombotic disease (_____) Hereditary disease (_____)
Hemophilia (_____) Uterine cancer (_____) Ovarian cancer (_____) Breast cancer (_____)
Other Cancer: (_____) Tuberculosis (_____)

【 4 】 Pregnancy / Delivery History

- ① Number of pregnancies ⇒ _____ times (If you are currently pregnant, please specify number excluding this pregnancy)
Normal delivery _____ times Miscarriage _____ times Abortion _____ times Ectopic pregnancy _____ times
Caesarean section _____ times Stillbirth _____ times Hydatidiform mole _____ times

② Birth date • Number of gestational weeks at birth • Birth weight etc.

	Birth date	weeks	sex	weight	condition	Delivery style mark ○ to applicable items	Special notes during pregnancy / delivery	Name of facility of delivery
1	· ·		M • F	g	alive • not	Normal • C-section • Others		
2	· ·		M • F	g	alive • not	Normal • C-section • Others		
3	· ·		M • F	g	alive • not	Normal • C-section • Others		

Please fill in the reverse side. →

【 5 】 Medical history (Please attach ✓ to the items that apply to the disease or surgery you have ever received.)

Internal medicine (Please circle as applicable.)

[Diabetes · Hypertension · Kidney disease · Liver disease · Allergy · Asthma · epilepsy · glaucoma

Cardiac disease · Arrhythmia · Thyroid disease · Tuberculosis · Others (disease :)]

Gynecology (disease name :) Surgery (disease name :)

Psychosomatic medicine (disease name :) Psychiatry (disease name :)

↓

Surgical experience [yes · no] If yes, [Surgery name :] transfusion [yes · no]

【 6 】 Please fill in any regular medicines (Including supplements) ⇒ [medicine name :]

【 7 】 Smoking · Drinking alcohol

Smoking history [yes · no] If yes, ⇒ Do you still smoke now? [no · yes ⇒ _____cigarettes/day]

Drinking alcohol [no · yes ⇒ about _____mL/ day · week · month]

Doctor's signature