Gynecology Questionnaire

Consultation date /YY /MM /DD ID

Furigana: Name:	Age ( )
Blood type:	Type ( ) Rh (＋ －) Height ( ) cm Weight ( ) kg
Address:	〒
Phone number:	Occupation:

1	Reason for visit (Please circle around all applicable answers.) Atypical genital bleeding Lower abdominal pain Menstrual irregularity Dysmenorrhea (Cramps, headache) Vaginal discharge Itchiness Pregnancy diagnosis (If pregnant, I would like to give birth/abortion/undecided) Consultation on contraception (Pill, IUD) Cancer screening Minato Ward Uterine cancer screening Pre-marital checkup Placental injection IV Vitamin therapy Others ( )
2	Menstrual history First menstruation: Age ( ) Menopause: Age ( ) Last period (From /MM /DD, For days) Menstrual cycle (Regular days, Irregular)
3	Marriage, pregnancy, and delivery Are you married? (Yes Married on /YY /MM, No) Have you had sexual intercourse? (Yes No) Pregnancy times Delivery times Artificial abortion times Miscarriage times
4	Have you visited a gynecology? (No Yes) Do you have any gynecological disease? No Yes (Name: Treatment:) Have you ever had a serious illness? No Yes (Name:) Are you in therapy for any disease? No Yes (Name: Internal medicine:) Do you have any allergies? No Yes ( ) Do you smoke cigarettes? No Yes How Many? /day For ( )years
5	Does anyone in your family had cancer or other serious illness? (Relationship: Name of disease:)
6	May we send you general updates from our clinic? No Yes (By mail E-mails (Address:)
7	How did you find our clinic? Advertisement on newspaper Signboard Signboards at stations Magazine ( ) Internet (Website Search engines 【 】) Acquaintance (Name:)

AZABUJUBAN MANAMI WOMEN'S CLINIC