聖路加国際病院
St. Luke's International Hospital

WOMEN'S HEALTH MEDICAL HISTORY QUESTIONNAIRE ☐診察済 ☐入力済 ☐紹介状有

(Department of Integrated Women's Health)

Name (Last, First, Middle):	Patient Registration Card Number:	Age:	Date of Birth: / /

Please fill out in red ball-point. Then, hand it in to the Department of Integrated Women's Health Reception desk.

Address _____ Height _____ cm Weight _____ kg(before pregnancy)

Occupation _____ Nationality _____

Telephone number **Daytime:** _____ Home/Office/Others

Nighttime: _____ Home/Office/Others

Mobile Phone: _____

* **Would you mind mentioning the name of the hospital, when we make a call?** ☐**Yes** ☐**No**

PLEASE ANSWER THE FOLLOWING QUESTIONS.

Reason for your visit today *Please contact the Breast Center about matters of breasts.

Stopping menstruation (☐None ☐Stop ☐Pregnant test Date _____/_____/_____Result － ＋)

☐Child birth at this hospital (Due date_____/_____/_____)

☐Nausea(吐き気) ☐Pregnancy test (妊娠検査) ☐Irregularity of Menstruation (月経不順) ☐Menstrual pain (月経痛)

☐Menstrual bleeding (heavy ,light) (月経出血 多量・少量) ☐Abnormal vaginal bleeding (不正出血) ☐Lower abdominal or back pain (下腹部痛 /腰痛)

☐Abnormal vaginal discharge (膣分泌物異常) (red, pink, brown, yellow, white, smell, others _____)

☐Irritation of pubic area (外陰部炎症) ☐Pain in private area (陰部痛) ☐Vulvar bumps (外陰部のしこり)

☐Fibroid (子宮筋腫) ☐Ovarian tumor(卵巣嚢腫腫瘍) ☐Endometriosis (内膜症) ☐Uterine Cancer Test (子宮がん検査)

☐Hot flush・perspiration・stiff shoulder(ほてり・発汗・肩凝り) ☐Pain on urination (排尿痛) ☐Wanting a child (子どもがほしい)

☐Pain during sexual intercourse (性交痛) ☐Sexually transmitted disease test (性病検査)

☐Descensus uteri (子宮下垂症) ☐Menopause disorder(更年期障害) ☐Adjusting the menstrual cycle(月経周期の調整)

☐Prenatal diagnosis (amniotic fluid, triple marker)(出生前診断) ☐Drug counseling in pregnancy (妊娠中の薬の相談)

☐Counseling for contraception (避妊の相談) ☐Referral letter from another hospital (紹介状) ☐Others ( )

Menstrual Pattern

1) First menstruation (Age of onset)_____years old Menopause_____years old

2) ☐Regular Length of Cycle Always_____days.

☐Irregular Length of Cycle shortest_____days, longest_____days

※Cycle: length from the first date of menstrual period till just before the next period (about 24 to 36 days?)

3) Menstrual period about_____days

4) At time of menstrual period do/did you have (please check)

☐Lower abdominal pain ☐Backache ☐Headache ☐Others( )

If yes, it is/was ☐severe ☐ moderate ☐ light

Amount (please check) ☐Heavy ☐moderate ☐light

5) The start date of your last menstrual period?_____ How long_____days

The date of your menstrual period before your last period?_____How long_____days

Was it as usual? ☐ Yes ☐No

6) Do you check your body temperature everyday? ☐ Yes ☐ No

Marital Status Please Check and give age.

☐Unmarried ☐In a relationship ☐Under an engagement

☐Married ( ) ☐ Divorced ( ) ☐Widowed ( ) ☐Second marriage( ) ☐Living together ( )

Have you ever had sexual intercourse? ☐ Yes ☐ No

Husband's/Partner's

Age_____ Nationality _____ Occupation _____

Health history

Past_____

Present _____

〒104-8560 東京都中央区明石町 9 番 1 号 Tel.03-3541-5151 Fax. 03-3544-0649

Pregnancies Have you been pregnant? ☐Yes ☐No

Past Pregnancies

No	Year	Abortion Miscarriage Ectopy Still birth Live birth	Delivery Normal, Vacuum Forceps,Cesarean (Please give reason)	Complications (Please give details) Self or Baby	Baby's Sex M/F Weight	Healthy or Unwell (Please give details)
1						
2						
3						
4						
5						
6						

Habits

Alcohol	Amount per day	How many times per week	Smoking	Amount per day	How many times per week

Your Past Health Have you had any serious illnesses in the past? If yes, please check and give age.

☐Pneumonia (肺炎)( ) ☐Tuberculosis (結核) ( ) ☐Pleurisy(肋膜炎) ( ) ☐Heart disease (心臓病) ( )
☐_____Cancer (癌) ( ) ☐Asthma(喘息) ( ) ☐Cerebrovascular disease(脳血栓疾患) ( )
☐High blood pressure (高血圧) ( ) ☐Atopy (アトピー)( ) ☐Stomach or colon problems (胃/結腸疾患) ( )
☐Liver disease (肝臓病) ( ) ☐Kidney disease(腎臓病) ( ) ☐Peritonitis (腹膜炎) ( )
☐Venereal disease (性病) ( ) ☐Diabetes (糖尿病) ( ) ☐Rheumatism (リウマチ) ( )
☐Others ( )( )

Have you ever had an operation for any of the following? If yes, please check and give age.

☐Appendicitis (虫垂炎)( ) ☐Fibroid (子宮筋腫) ( ) ☐Ovarian cyst (卵巣のう腫) ( )
☐Extopic pregnancy(子宮外妊娠)( ) ☐Tubal ligation (卵管結紮)
☐Others ( ) ( )

Your Present Health

1) Are you allergic to any medications or pollen? Please give name. _____

2) Do you have any health problems at present? Please explain briefly _____

3) Are you currently taking any medications? Please give name and dosage. _____

Family Health History

Parents or Brother	Age	Additional present health problem	Deceased (please give age and cause)
Father			
Mother			

Others

1) What is your religion?

Do you have any religions or cultural practices that are important to you during this hospitalization? ☐ Yes ☐ No

If yes, please describe _____

2) In this hospital, patients are treated with blood tranfusion when deemed medically necessary during an examination, treatment or surgery .

Do you agree to undergo blood transfusion? ☐ Yes ☐ No

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