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 using a red ballpoint pen. Then, hand it in at the Department of Integrated Women's Health Reception desk.

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

Occupation _____ Nationality _____

Telephone number **Daytime:** _____ Home/Office/Other **Nighttime:** _____ Home/Office/Other

Mobile Phone: _____

* **May we mention the name of this hospital if we were to call you on your Mobile Phone (No. _____)? □Yes □No**

PLEASE ANSWER THE FOLLOWING QUESTIONS.

Reason for your visit today *Please contact the Breast Center concerning matters related to the breasts.

□Pregnancy test Date ___/___/___ Result − + □Childbirth at this hospital (Due date___/___/___)

□Menstrual abnormalities（月経の異常）

（□Menstruation has never occurred（月経がきたことがない） □Menstruation started, but stopped coming（途中からこない）

□Menstrual bleeding heavy（量が多い） □Menstrual bleeding light（量が少ない） □Menstrual pain（月経痛） □Irregular menstruation（生理不順）

□Non-menstrual abdominal/lower back pain（月経以外の腹痛・腰痛がある） □Abnormal vaginal bleeding（不正出血）

□Drug counseling in pregnancy（妊娠中の薬の相談）

□Fibroid（子宮筋腫） □Ovarian tumor（卵巣嚢腫腫瘍） □Endometriosis（子宮内膜症）

□Wish to undergo testing（検査の希望）（□Uterine Cancer Test（子宮癌検査） □Sexually transmitted disease test（性病検査））

□Re-test of comprehensive check-up results（人間ドックの再検査）（Test items（検査事項）: _____ ）

□Abnormal vaginal discharge（おりものの異常）

（□Heavy discharge（おりものの量が多い） □Staining by the color of the discharge（色がつく） □Foul smell（においがする））

□Abnormalities of the genital area（陰部の異常）（□Itching（かゆみがある） □Pain（痛みがある） □There is a lump（しこりがある））

□Wishing to conceive a child（子どもがほしい） □Pain during sexual intercourse（性交障害） □Menopause disorder（更年期障害）

□Hot flushes・perspiration・stiff shoulder（ほてり・発汗・肩凝り）

□Wish to undergo amniotic fluid testing/triple marker test（羊水検査・トリプルマーカーを受けたい）

□Concerned about hereditary/birth defects（遺伝や先天異常が心配）

□Consultation on contraception（避妊の相談） □Others（ _____ ）

Menstrual Pattern

First menstruation (Age of onset) _____ years old Menopause _____ years old

Most recent menstruation: from Month DD, Year for _____days

The menstruation before that from Month DD, Year for _____days

Month DD, Year for _____days

Menstrual cycle: Normally it is _____days; when it comes early, it is about _____days and when it comes late, it is _____days

Menstrual cycle: Period from the first day of menstruation until the first day of the next menstruation (in days), usually between 24 to 36 days.

Pregnancies Have you had sexual intercourse? □Yes □No Have you been pregnant? □Yes □No

	Year (date) of pregnancy	Normal	Premature birth	Miscarriage	Aborted	Ectopic pregnancy	Hydatidform mole	Birth: Normal, suction, forceps, caesarean section (reason)	Postpartum: Normal / Abnormality	Please answer about the child		
										Weight at birth	Sex	Healthy?
1										g		
2										g		
3										g		
4										g		
5										g		

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

Please answer about your partner and your own family members.

☐Marriage（Month YY at age ） ☐Unmarried ☐Engaged ☐Partner has died（at age ） ☐Divorced（at age ）
☐Remarried（at age ）
☐Partner age:_____ ☐Healthy ☐Disease (Diagnosis:)
Nationality ☐Japan ☐Others (Name:) Occupation
☐Father, age:___ ☐Healthy ☐Disease (Diagnosis: ） Died, at age Cause of death
☐Mother, age:__ ☐Healthy ☐Disease (Diagnosis: ） Died, at age Cause of death
☐（ ） age:__ ☐Healthy ☐Disease (Diagnosis: ） Died, at age Cause of death
☐（ ） age:__ ☐Healthy ☐Disease (Diagnosis: ） Died, at age Cause of death
☐（ ） age:__ ☐Healthy ☐Disease (Diagnosis: ） Died, at age Cause of death

Please answer about past diseases/surgery

Past diseases ☐No ☐Yes → ☐Hypertension ☐Diabetes ☐Asthma ☐Others（ ）
Past surgery ☐No ☐Yes → Name of surgery and age：at age____ Name of surgery（ ）
Diseases presently under treatment ☐No ☐Yes → ☐Hypertension ☐Diabetes ☐Asthma ☐Others（ ）
Drugs presently used（ ）
Do you have any allergies to drugs or foods? ☐No ☐Yes → Drugs（ ） Others（ ）

Please answer about your lifestyle habits.

Cigarette smoking ☐I smoked in the past, but not now ☐I don't smoke ☐I smoke → Number of cigarettes (____) /day x ____years
Alcohol ☐I drink (e.g., 1 bottle beer/day) → kind of alcohol how much ( )/day ☐I don't drink
Do you have any religious restrictions on your lifestyle ☐No ☐Yes （ ）

◆ At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary.
Do you agree to undergo blood transfusion in the event it becomes medically necessary?

☐Yes ☐No

※ **Data obtained during treatment may be presented at academic conferences or published in academic journals, but only to the extent that it is impossible to identify any individuals and personal information is protected. Thank you for your understanding.**

SLIH-2019.9.5-Ver.5.00

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