WOMEN'S HEALTH MEDICAL HISTORY QUESTIONNAIRE

(Department of Integrated Women's Health)

*Please fill in the below with a red pen and submit it to the receptionist.

Name:	Patient ID Number:	Date of Birth:	Age:

Address: _____

Phone Number: _____ (Home / Cell)

***May we mention this hospital's name when we call? (☐ Yes ☐ No)**

Nationality: _____ Occupation: _____ Height: _____ cm Weight: _____ kg

1. Please tell us the purpose of your visit today. *Please inquire with our Breast Center for matters regarding your breasts.

   ☐ I wish to deliver my baby here (Due date: _____ / Undecided)

   ☐ Menstrual abnormalities → ☐ Never menstruated ☐ Menstruation stopped over time ☐ Irregular menstruation ☐ Heavy menstruation ☐ Light menstruation ☐ Strong pain

   ☐ Irregular bleeding ☐ Abdominal pain ☐ Lower back pain ☐ Abnormal discharge (☐ Large amount ☐ Colored ☐ Off-smelling)

   ☐ Fibroids ☐Ovarian cystoma ☐Endometriosis ☐ Genital abnormalities ☐ Possible cancer

   ☐ Lowered uterus ☐ Test for sexually-transmitted infections ☐ I want to have children

   ☐ Consultation on contraceptives

   ☐ Menopausal symptoms (Specific symptoms: _____)

   ☐ Request for test → ☐ Instructed for further screening (☐ Cervical cancer screening ☐ Endometrial cancer screening ☐ Other: _____)

   ☐ I want a prenatal test; I'm worried about genetic or hereditary abnormalities

   ☐Other/I want to discuss my progress or other matters_____

2. Please tell us about your menstruation.

   First period: Around _____ years old Menopause: Around _____ years old

   Most recent period: Started on (YYYY)_____(MM)_____(DD)_____ and lasted _____ days

   Menstrual cycle (Number of days from the day your period starts until the day your next period starts):

   _____ -day cycle / Lasts _____ days

   When early, it comes around the (DD)_____. When late, it comes around the (DD)_____. (Regular / Irregular)

   Pain (severe / mild / none) Amount (heavy / normal / light)

3. Do you have any allergies? ☐ No ☐ Yes

   Medication: _____ Foods: _____

   Other (Latex, pollen, etc.): _____

   What symptoms did you develop and at around what age? _____

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4. Please tell us about your pregnancy/childbirth history.

*Have you ever had sexual intercourse? ☐ Yes ☐ No *Have you ever been pregnant? ☐ Yes ☐ No

Year and outcome of past births/miscarriages		Weeks at gestation during birth	Delivery method	Complications	Children
Year	Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar pregnancy	____weeks	Vaginal (Epidural/vacuum/forceps) Caesarean section (Reason:______________)	No Yes (____________ ____________)	Weight at birth: ____ g Sex: M / F Past/Current Illnesses: ____________________
Year	Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar pregnancy	____weeks	Vaginal (Epidural/vacuum/forceps) Caesarean section (Reason:______________)	No Yes (____________ ____________)	Weight at birth: ____ g Sex: M / F Past/Current Illnesses: ____________________
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Year	Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar pregnancy	____weeks	Vaginal (Epidural/vacuum/forceps) Caesarean section (Reason:______________)	No Yes (____________ ____________)	Weight at birth: ____ g Sex: M / F Past/Current Illnesses: ____________________

5. Please tell us about your partner and your family (excluding your children).

*Please include information regarding hypertension, diabetes, cancer, mental illness, and sudden death.

☐ Not married ☐ To be married soon ☐ Married (Month _____Year: _______ Age: ____)

☐ Divorced (Year: _______ Age: ____) ☐ Widowed (Year: _______ Age: ____)

☐ Remarried (Month _____Year: _______ Age: ____)

Partner: _____ years old (Nationality: _________________) (Occupation: _________________) ☐ Healthy

☐ Ill (Name of illness: ________________________________)

☐ Father: ___ years old ☐ Healthy ☐ Ill (Name of illness: ________________________________)

☐ Estranged ☐ Deceased (Age: ____)

☐ Mother: ___ years old ☐ Healthy ☐ Ill (Name of illness: ________________________________)

☐ Estranged ☐ Deceased (Age: ____)

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☐ Big brother / Big sister / Little brother / Little sister: ____ years old ☐ Healthy
☐ Ill (Name of illness: _____) ☐ Deceased (Age: ____)
☐ Big brother / Big sister / Little brother / Little sister: ____ years old ☐ Healthy
☐ Ill (Name of illness: _____) ☐ Deceased (Age: ____)
☐ Big brother / Big sister / Little brother / Little sister: ____ years old ☐ Healthy
☐ Ill (Name of illness: _____) ☐ Deceased (Age: ____)

6. Please tell us about your history of illness.（Including hypertension, diabetes, asthma, and other illnesses）
Year: _____ Age: _____ Name of illness: _____ Current medications: _____
Year: _____ Age: _____ Name of illness: _____ Current medications: _____
Year: _____ Age: _____ Name of illness: _____ Current medications: _____

- Other medications/supplements:_____
- Have you ever had surgery? ☐ No ☐ Yes
  Year: _____ Age: _____
  Year: _____ Age: _____
- Have you ever consulted with a psychological counselor, psychotherapist, or psychiatrist? ☐ No
  ☐ Yes (When?:_____ Reason:_____ Name of clinic/hospital:_____
  ☐ Forgotten)

7. Please tell us about your lifestyle habits.
- Smoking: ☐ I have never smoked.
  ☐ I used to smoke but no longer do (From age ____ to age ____. About ___ cigarettes per day)
  ☐ I currently smoke (From age ____. About ____ cigarettes per day)
- Alcohol: ☐ I do not drink ☐ I drink: (Type: _____ Amount: _____ ml per day)
  ☐ I stopped drinking after getting pregnant
- Religious limitations: ☐ No ☐ Yes (Details: _____)

8. Please circle the below number that best averages how difficult the past week has been for you.
Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

To what extent did that difficulty affect your daily life?
Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

9. At this hospital, we perform blood transfusions when deemed medically necessary during tests, procedures, and surgeries. Do you consent to undergoing blood transfusions? ☐ Yes ☐ No

Thank you for filling out this form. Please submit it to the receptionist.

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