

## First Visit Questionnaire

Reception: MM DD ,YYYY \_\_\_\_\_ Expected due date: MM DD ,YYYY \_\_\_\_\_

Name			Patient ID Number	—		
Address	〒			Nationality:	Age	years old
				Date of Birth	mm/dd/yyyy	
Contact	Mobile phone number:					
	Emergency number 1:	(Name	Relationship	)		
	Emergency number 2:	(Name	Relationship	)		
Occupation		Height	cm	Weight (non-pregnant)	kg	

If we call to contact you from the hospital, may we mention the name of the hospital?  Yes  No

1. Please answer the following questions about your menstruation.

- My first period started when I was \_\_\_\_\_ years old
- My most recent menstruation was from MM DD , YYYY for days  
The menstruation before that was from MM DD , YYYY for days
- Pain during menstruation is  very strong (use painkillers)  normal  no pain
- Menstrual cycle: Usually \_\_\_\_\_ days, \_\_\_\_\_ days when early, and \_\_\_\_\_ days when late  
\*The menstrual cycle is calculated from the first day of a period until the next period starts.

2. Please tell us about your past pregnancies and deliveries (please circle the applicable answer or fill it out)

Year and month	Normal	Miscarriage	Abortion	Ectopic pregnancy	Vesicular mole	Mode of delivery/ time required	Abnormalities before/after delivery (premature delivery, excessive bleeding)	About the child				
								Gestational age in Weeks when born	Birth Weight	Gender	Is your child healthy?	Place born
						/			g			
						/			g			
						/			g			
						/			g			

3. Please tell us about your past diseases and surgeries. (Please  the appropriate answer.)

I have been diagnosed with a gynecological problem before:  No  Yes (⇒If YES, please answer the following questions)

- Uterine myoma ( Not treated  Surgery on (yy/mm / )
- Endometriosis ( Not treated  Surgery  Under treatment: from / )
- Ovarian cyst ( Not treated  Surgery  Under treatment: from / )
- Diseases other than the above (please describe in detail: from / )

I have been diagnosed with other diseases  No  Yes (⇒If YES, please answer the following questions)

- Asthma ( Cured  Using oral/inhalation drug: name of drug from / )
- High blood pressure ( Not treated  Under treatment: from / )
- Diabetes ( Not treated  Under treatment: from / )
- Psychiatric disease ( Took medicine before: name of drug: from / )  
 Currently taking medication: name of drug: from / )
- Others (Please describe in detail: from / )

I have undergone surgery:  No  Yes (⇒Period of treatment and operative method: from / )

I have received blood transfusion or blood products  No  Yes (⇒

Reason: )

I have been hospitalized outside of Japan within the past 5 years:  No  Yes (⇒Country: Reason: )

Allergies  No  Yes

⇒(Food: from / )

(Medication: from / )

\*Please fill out the back side as well

St. Luke's Maternity Care Home

4. Please tell us about your partner and your family. (Please tick  the appropriate answer.)
- Married (MM YYYY at age: )  Unmarried  Planning to get married  Widowed (age: )
  - Divorced (age: )  Second marriage (age: )
  - Please tell us about your partner.  
Occupation ( ) Date of birth (MM DD , YYYY ) Age ( )  
Nationality  Japan  Other ( )  
Condition of health  Healthy  Has illness ( )
  - Please tell us about your family.  
Father age:  Healthy  Has illness (Treatment: )  Passed away (age : reason )  
Mother age:  Healthy  Has illness (Treatment: )  Passed away (age : reason )  
( ) age:  Healthy  Has illness (Treatment: )  Passed away (age : reason )  
( ) age:  Healthy  Has illness (Treatment: )  Passed away (age : reason )
5. Please tick  the family members you reside with.  
 Husband or partner  Children ( kids)  Father  Mother  Father-in-law  Mother-in-law  Other ( )
6. Please tell us about your lifestyle. (Please tick  the applicable answers.)
- Tobacco  Don't smoke  Smoke cigarettes/day for years  Used to smoke cigarettes/day for years
  - Husband(partner)  Doesn't smoke  Smokes cigarettes/day for years  Used to smoke cigarettes/day for years
  - Alcohol  Don't drink  Drink glasses/bottles of /day for years  
 Used to drink glasses/bottles of /day for years
  - Bowel movements times/day
  - Bedtime  Regular : at AM/PM  Irregular
  - Sleeping hours  Regular: hours  Irregular)
  - Are you sensitive to cold?  No  Yes (I take countermeasures  Yes  No)
7. Please tell us about your relationship with your husband (partner) for the past year. Please circle one answer.
- Do you ever feel scared by your partner's words and actions?  
① Frequently      ② Sometimes      ③ Never
  - Does your partner punch the wall or throw things when he is angry?  
① Frequently      ② Sometimes      ③ Never
  - Does your partner force you to engage in sexual activity even when you do not feel like it?  
① Frequently      ② Sometimes      ③ Never
  - Does your partner ever act aggressively, such as hitting, pushing or pulling your arm strongly?  
① Frequently      ② Sometimes      ③ Never
8. Please answer the questions about your feelings over the past month. Please tick  the applicable answer.
- ① Are you often plagued by feelings of depression, listlessness or hopelessness?  Yes  No
  - ② Are you often plagued by not being interested in things you have to do and unable to enjoy things?  Yes  No
  - ③ Do you feel stressed, anxious or nervous almost every day?  Yes  No
  - ④ Do you feel that you cannot stop worrying or control your fears almost every day?  Yes  No
9. Are there any religious restrictions on what you may do? Please tick  the appropriate answer.  
 No  Yes (⇒Please specify: )
10. 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 that it becomes medically necessary?  Yes  No
11. In case of a situation in which you cannot decide on your treatment course, is there someone you prefer to make the decision on your behalf?  No  Yes (⇒Who? )
12. If you have any questions about your pregnancy course at present or about today's check-up, please write them here.

© We may use the data obtained during the consultation in presentations for academic meetings, etc., but no information that may identify you personally will ever be used. Thank you for your understanding.