聖路加国際病院附属クリニック 聖路加メディローカス

St. Luke's MediLocus

WOMEN'S HEALTH MEDICAL HISTORY QUESTIONNAIRE

Name:	Date of Birth: / /

Height cm Weight kg

1. Reason for your visit today

□Abnormality of Menstruation (□Absent menstruation □Irregular cycle □Heavy bleeding □Severe cramps □Others)
□Abdominal or back pain unrelated to menstruation
□Any bleeding or spotting between menstrual cycles
□Re-examination after medical checkup (specify:_____)
□Abnormal vaginal discharge / genital abnormality (□Heavy/colored □Irritation □Pain □Lump)
□Menopausal concerns
□Birth control consultation
□Others (specify:_____)

2. Menstrual History

・Age of the first period_____ years old ・In menopause →Age of menopause _____ years old
・Recent period started on _____/_____/_____for_____days
・Previous period started on _____/_____/_____for_____days
・Menstrual Cycle Regular:_____days（Shortest:_____days, Longest:_____days）

3. History of sexual intercourse, pregnancy and labor

(If you do not wish to answer, please tell your physician directly.)
・Have you ever had sexual intercourse? □No □Yes
・Have you ever been pregnant? □No
□Yes If yes, specify: □Normal delivery___times □Caesarean section___times
□Miscarriage___times □Abortion___times □Ectopic pregnancy___times
□Trophoblastic disease___times

4. Past Medical History

・Have you ever had any illnesses? □ No
□Yes If yes, specify：□Hypertension □Diabetics □Asthma
□Others_____
・Have you ever had any surgeries? □ No
□Yes If yes, specify:
Age:_____ Type of Surgery:_____
Age:_____ Type of Surgery:_____
・Are you currently under treatment? □ No
□ Yes If yes, specify: □Hypertension □Diabetics □Asthma □Others_____
・Are you currently taking any medications (Including supplements) ?
□ No
□ Yes If yes, specify: all medications _____
・Do you have allergies to any medications or food?
□No
□Yes If yes, specify medications _____ Others _____

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Tel.03-3527-9520 Fax. 03-3281-5630

5. Social History

・Do you smoke cigarettes now? □Never
□Former □Current How many? _____ cigarettes/day How long? _____ years

・Do you drink alcohol? □No
□Yes What kind/How many? ____/_____ml/day

・Do you have any religions or cultural practices that are important to you during this hospitalization?
□ No
□ Yes If yes, please describe _____

6.Please circle the below number that best averages how emotionally stressed the past week has been for you.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

7.To what extent did your emotional stress interfere with your daily life activities?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely

8. At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary.

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

9. Family History

・Father: Age ____ □Healthy □Illness_____□Deceased Age ____ Cause of death_____
・Mother: Age ____ □Healthy □Illness_____□Deceased Age ____ Cause of death_____
Brothers/sisuters,grandparents,etc.
・( ) Age ____ □Healthy □Illness_____□Deceased Age ____ Cause of death_____
・( ) Age ____ □Healthy □Illness_____□Deceased Age ____ Cause of death_____

10. Your contact information.

Address: _____
Phone: _____ (Cell phone ・ Home ・ Work)
* Would you mind mentioning the name of the hospital when we make a call? □Yes □No

11.How did you hear about us?

☐Posters/pamphlets ☐HP ☐St. Luke's International Hospital ☐Another medical institution
☐Place of employment introduced ☐Family/friends introduced
☐Others（ ）

***We may use and disclose your health information on a de-identified basis for research purposes. We appreciate your support and understanding.**

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