Medical Interview Sheet

/ / (Day/Month/Year)

Name: ____________________

1 What brought you in today?

(1) Regarding pregnancy

( ) You think you're pregnant ( ) You're pregnant

Did you take a pregnancy test? (Yes / No) (Date tested: / , Result: positive / negative)

When is the result due? (Due date /)

Do you want to keep the child? (Yes / No)

(2) Other symptoms

( ) Itching of the vulva

( ) Vaginal discharge

( ) Abnormal vaginal bleeding

( ) Low abdominal /Abdominal pain

( ) Something Else ( )

( ) Menstrual pain

( ) consultation about infertility

( ) Irregular menstruation

( ) I was diagnosed the following gynecological disease in another hospital

( )

( ) Menopausal disorder

( ) Oral contraceptive pill (low dose / emergency contraception / to change menses)

( ) Uterine prolaps

( ) Anxiety about a Sexually Transmitted Disease

( ) Bladder inflammation

(3) Health check

( ) Cancer examination

( ) Sexually Transmitted Disease examination

( )Other( )

2 With regard to menstruation

•When did you start menstruation? ( ) years old, age at menopause ( )years old

•Are your periods regular ? (Yes / No)

•When was your last period? (/ /) day/Month/year ( ) days

•What's the period of your cycle? ( )days(28 days for example)

How many days does it last? ( ) days

•Menstrual blood loss(low / medium / heavy)

•Menstrual pain (none / weak / medium / strong) Do you usually take a painkiller for it?

(Yes / No)

3 Regarding marriage, pregnancy, delivery

•Are you married?

(　) Yes: First marriage / Remarriage

(Age and health of your husband 　 years old, (in good health / has a disease)

(　) No: Unmarried / Divorced / widow

•Did you have sexual intercourse? Yes / No

•Have you become pregnant before? Yes / No

•If yes, what was the result? Childbirth / Miscarriage / Abortion

	Day/Month/Year , Weeks	Birth way (Normal birth /Caesarean op)		Birth weight (g)	Abnormality during Pregnancy or delivery
①		Normal/ Caesarean	Our clinic/ other		
②		Normal/ Caesarean	Our clinic/ other		
③		Normal/ Caesarean	Our clinic/ other		

4 Past medical history

(1) Have you ever had a disease? (Yes / No)

Diabetes / High blood pressure / Cancer (　)

/ Cardial, Kidney, Hepatic diseases / Gynecological disease

(2) Have you ever had any operations before? (Yes / No)

Appendicitis / Operation of the Uterus or Ovary / Other(　)

(3) Have you ever had any allergies? (Yes / No)

Asthma / Hay fever / Other(Food: 　 , Medicine: 　 ,.Other: 　)

(4) Are you taking any medicine? (Yes / No)

(　)

(5) Have you ever received blood transfusion? (Yes / No)

5 Do you have a family history of any medical diseases?

6 Do you have any questions? Or does something else bother you?