

Minami Ladies Clinic Questionnaire

Year _____ month _____ day _____

Name

Date of birth _____ / () Years old

Address

Phone

Nationality _____

Height _____ cm Weight _____ kg

Check all corresponding answers.

1. What is wrong with you?

- | | | |
|---|--|--|
| <input type="checkbox"/> pregnancy | <input type="checkbox"/> irregular period | <input type="checkbox"/> vaginal discharge |
| <input type="checkbox"/> irregular genital bleeding | <input type="checkbox"/> oophoroma | <input type="checkbox"/> vaginal itching |
| <input type="checkbox"/> cancer check | <input type="checkbox"/> uterine leiomyoma | <input type="checkbox"/> urine troubles |
| <input type="checkbox"/> stomachache | <input type="checkbox"/> hope for being pregnant | |

2. Menstrual history

- * When did your first period start? _____ Years
- * When was your menopause? _____ Years
- * Are periods regular? No Yes
- * Menstrual flow heavy normal light
- * Do you suffer from any pain during your period?
- * Date of your last period _____ month _____ day

3. History of pregnancy

- pregnancy _____ times
- delivery _____ times normal delivery _____ times (Y/ M)
- Caesarean section _____ times (Y/ M)
- miscarriage _____ times natural abortion _____ times
- artificial abortion _____ times
- others

4. Do you want to deliver or not deliver, if you are pregnant?

- No Yes

5. Have you ever been allergic to medication or food?

- No Yes

6. Have you ever had any operation?

- No Yes

7. What illnesses have you had in the past?

Thank you for cooperation