

# Obstetric and Gynecologic Inquiry Form 産婦人科問診票



Year Month Day  
20\_\_年\_\_月\_\_日

It is very important to know your medical history and state of health. All information given here is strictly confidential.  
あなたの既往症と体調を事前に把握しておく事は大切な事です。以下の項目にお答え下さい。個人情報の秘匿は守られます。

## General Patient Information 患者の情報

フリガナ:

Last name 姓		First name(s) 名	
Nationality 国籍		Language(s) 言語	
Date of Birth 生年月日	Year: □□□	Month: □□	Day: □□
Occupation 職業		Address in Japan 日本での住所	
Phone number 電話			
E-mail/fax メール・ファックス			

## Chief Complaint(s) 主訴 □□□ If none, go to next section

- |   |  |
|---|--|
| <input type="radio"/> Pregnancy or possible pregnancy<br>妊娠又は妊娠の可能性                 | <input type="radio"/> Sterility 不妊症  |
| <input type="radio"/> Irregular periods or irregular vaginal bleeding<br>生理不順又は不正出血 | <input type="radio"/> Infection (possible sexually transmitted disease)<br>感染症(性感染症) |
| <input type="radio"/> Vaginal discharge おりもの  | <input type="radio"/> Stomachache 腹痛   |
| <input type="radio"/> Other (please write) 他  |  |

How long have you had this? どのくらい? \_\_\_ hour(s) 時間 □□□ day(s) 日間 □□□ week(s) 週間 □□□ month(s) ケ月 \_\_\_ year(s) 年間

## I wish to have... 以下の受診希望 □□□ If none, go to next section

- |  |  |  |
|--|--|--|
| <input type="radio"/> Contraceptive medicine 避妊薬 | <input type="radio"/> A gynecological checkup referral<br>婦人科医への紹介 | <input type="radio"/> An abortion 人工流産   |
| <input type="radio"/> A regular checkup 定期健診     | <input type="radio"/> A sterility test 不妊症の検査                      | <input type="radio"/> A check to determine the cause of my anemia<br>貧血の原因チェック |
| <input type="radio"/> A Pap (vaginal) smear がん検診 |  |  |
| <input type="radio"/> Other (please write) 他     |  |  |

## Menstrual Period 生理に関する質問

Are you in your menopause? 更年期ですか No  Yes  **Go to next section**

Have your periods been regular? 順調ですか No  Yes  Frequency of periods: 周期は □ Every \_\_\_ days 日毎

When was your last period? 最終月経は Month: \_\_\_ 月 Day: \_\_\_ 日 Duration of each period: 持続期間は About \_\_\_ days 約~日

Volume of period 生理の量は Heavy  多い Normal  普通 Light  少ない Do you have period cramps? 生理痛は No  Yes

Please write anything else you want to consult the doctor about. 医師に相談したい事は

## Pregnancy History 妊娠歴

Number of times pregnant 妊娠回数 \_\_\_ 回 Number of miscarriages 自然流産 \_\_\_ 回 Number of abortions 人工流産 \_\_\_ 回

Have you had an ectopic pregnancy? 子宮外妊娠 No  Yes

Have you given birth? 分娩の経験

No  Yes  How many times? 何回? \_\_\_

Are you currently breastfeeding? 今、授乳中ですか No  Yes

Did you have any complications? 異常分娩 No  Yes  Please give details: 詳細を書いて下さい

## Pap Smear がん検診

Have you had Pap smear? 受けた事がありますか No  Yes  Time of last test: いつが最後の検査 Year \_\_\_ 年 Month \_\_\_ 月

**Go to REVERSE SIDE**

## Illness and Surgical History 既往歴、手術歴

Please select any illnesses you have had. 該当する疾患に印をつけて下さい

- |   |  |   |
|---|--|---|
| <input type="radio"/> High blood pressure 高血圧       | <input type="radio"/> Kidney disease 腎臓病     | <input type="radio"/> Convulsions or Epilepsy けいれん・てんかん |
| <input type="radio"/> Diabetes 糖尿病                  | <input type="radio"/> Liver disease 肝臓病      | <input type="radio"/> Tuberculosis 結核                   |
| <input type="radio"/> Heart disease 心疾患             | <input type="radio"/> Thyroid problems 甲状腺異常 | <input type="radio"/> Hepatitis B or C B/C型肝炎           |
| <input type="radio"/> Cerebrovascular disease 脳血管疾患 | <input type="radio"/> Asthma 喘息              | <input type="radio"/> HIV エイズ                           |

Other (please write) 他

Have you had any operations before? 手術歴

No  Yes  What? 何の手術

Have you had a blood transfusion? 輸血歴

No  Yes  What was it for? 何の為

Do you tend to bleed much? 出血傾向 No  Yes  Not sure  わからない

## Family History 家族歴

Please select any illnesses your immediate family have had. 親族での

- |   |  |   |
|---|--|---|
| <input type="radio"/> High blood pressure 高血圧 | <input type="radio"/> Kidney disease 腎臓病 | <input type="radio"/> Cancer 癌                    |
| <input type="radio"/> Diabetes 糖尿病            | <input type="radio"/> Liver disease 肝臓病  | <input type="radio"/> Hereditary diseases 遺伝子関連疾患 |

Other (please write) 他

## Allergies アレルギー

Have you ever been allergic to anything? (medicine, food, other) アレルギーの有無(薬、食べ物、他)

No  Yes  What? 何に

Have you had side effects caused by medicine? 薬の副作用の有無

No  Yes  Which medicine? 薬名

Have you had problems after having a local or general anesthetic? 全身又は局所麻酔歴

No  Yes  What? 何に

## Medication 薬

Are you currently taking contraceptive pills? 避妊用のピルを服用していますか No  Yes

Are you currently taking any other prescribed or over-the-counter medicine(s)? 今、他の処方薬又は売薬を服用していますか

No  Yes  Which medicine(s)? 何の薬を

Bufferin  Aspirin  Warfarin ('Coumadin,' 'Warfilone,' 'Marevan')

Other: Please write the medicine name(s). 薬名を具体的に書いて下さい

Why are you taking it/them? 何の為

## Alcohol and Tobacco お酒とタバコ

Do you regularly drink alcohol? お酒を定期的に飲みますか

No  Yes  How much in 1 week? 週にどのくらい? →

1 beer (500ml)



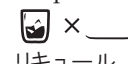
ビール500ml

1 glass of wine



グラスワイン

1 measure of spirits



リキュール

Other: その他

Do you smoke? タバコは吸いますか

No  Yes  How many a day? 一日に \_\_\_ 本 How long have you smoked? どのくらい \_\_\_ months ケ月間 \_\_\_ years 年間

Did you smoke before? 以前に吸ったことありますか

No  Yes  How many a day? 一日に \_\_\_ 本 When did you stop? いつやめましたか \_\_\_ months ago ケ月前 \_\_\_ years ago 年前

## Treatment Preferences and Medical Fees 治療の希望と医療費

Do you have Japanese Health Insurance or private medical insurance? 日本の保険証又は他の私的医療保険証をお持ちですか

No  Yes  Do you only want treatment covered by the insurance? 保険を使える治療だけを希望しますか No  Yes  Not sure  わからない

Do you only want treatment for your main problem? 現在困っている問題の治療のみ希望しますか

No  Yes  Not sure  わからない

Please return this form. Thank you.