Obstetric and Gynecologic Inquiry Form 産婦人科問診票

Year 20__年 Month ____月 Day ____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

Phone number 電話

E-mail/fax メール･ファックス

Address in Japan 日本での住所

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

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

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) ヶ月 ____year(s) 年間

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

- ◯ Contraceptive medicine 避妊薬
- ◯ A regular checkup 定期健診
- ◯ A Pap (vaginal) smear がん検診
- ◯ A gynecological checkup referral 婦人科医への紹介
- ◯ A sterility test 不妊症の検査
- ◯ An abortion 人工流産
- ◯ A check to determine the cause of my anemia 貧血の原因チェック
- ◯ 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? 受けた事はありますか 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

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

◯ Other (please write) 他 _____

Have you had any operations before? 手術暦
No◯ Yes◯→ What? 何の手術 _____

Have you had a blood transfusion? 輸血暦
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

- ◯ High blood pressure 高血圧
- ◯ Diabetes 糖尿病
- ◯ Kidney disease 腎臓病
- ◯ Liver disease 肝臓病
- ◯ Cancer 癌
- ◯ 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)	1 glass of wine	1 measure of spirits	Other: その他
 ×___	 ×___	 ×___	_____
ビール500ml	グラスワイン	リキュール	

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 ヶ月間 ___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 ヶ月前 ___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.

