



# MEDICAL QUESTIONNAIRE



白金高輪 EBINE WOMEN'S CLINIC  
海老根ウィメンズクリニック

First Visit • Return	ID	※Required										Year	Month	Day	
Name		Date of Birth	S	H	R				Age	Single	Occupation				
Address		Y	M	D				Yrs	Married						
Phone number to contact ※					Height			Weight		Body Temperature		Blood Pressure			
					cm			kg		°C		mmHg			

- How did you know about us?  (Multiple answers allowed)
- Website  Facebook  Bus Information  Billboard  Station Signboard  Magazine  Friends or Family  Doctor's file
- Had exams by Chief Physician before  Others ( )

## PLEASE FILL IN ABOUT REASONS FOR MEDICAL CONSULTATION (Multiple answers allowed)

### KUMIN KENSHIN-Checkup

#### OBSTETRICS AND GYNECOLOGY

- Abnormal Discharge: Color ( ), Smell (  Yes  No )
- Vaginal Itching
- Abnormal Bleeding ( \_\_\_\_ / \_\_\_\_ ~ )
- Abdominal Pains ( \_\_\_\_ / \_\_\_\_ ~ )
- Irregular Menstruation
- Premenstrual Syndrome (PMS)
- Warts
- Painful Intercourse
- STI Screening, Women's Wellness Exams
- Preparation for Conception, Ovulation Checkup, Infertility Consultation
- Menopausal Consultation

#### PILLS

- Contraception →  Low Dose pill
- Contraceptive Ring ※Please answer the screening test history section.
- Morning-After Pill (Date of Intercourse \_\_\_\_ / \_\_\_\_ )
- Moving Menstrual Cycle (Avoid \_\_\_\_ / \_\_\_\_ ~ \_\_\_\_ / \_\_\_\_ )

#### PEDIATRICS

- Adolescent consultation  Itching
- Discharge  Cold  Vaccinations
- Others ( )

#### BREAST SURGERY

- Are you pregnant?  No  Yes ● Are you breastfeeding?  No  Yes  Breast Cancer Screening
1. Symptoms  Lump  Pain  Lactation  Checkup  Others ( )
- When did it start? (Right • Left: )
2. Have you ever had breast cancer screening exams?  No  Yes → Ultrasound ( \_\_\_\_ / \_\_\_\_ ) Mammography ( \_\_\_\_ / \_\_\_\_ ) Visual & Palpation ( \_\_\_\_ / \_\_\_\_ )
3. Do you have any family member diagnosed with cancer?  No  Yes → ( )
4. Do you have a pacemaker implanted?  No  Yes → ( )
5. Do you have any breasts implants?  No  Yes → ( )

#### PREGNANCY

- Pregnancy Test (will give birth  Yes •  No)
- At-Home Pregnancy Test (  + •  - ) (Test Date \_\_\_\_ / \_\_\_\_ )
- Preferred hospital for delivery \_\_\_\_\_
- Routine Prenatal Exam
- 3D/4D Ultrasound
- Fetal Wellness Exams
- Postpartum Consultation
- Others ( )

#### ANTI-AGING, BEAUTY, FATIGUE RECOVERY

- Intravenous Drip (High-Dose Vitamin C, Placenta, Others)
- Injection (Placenta, Garlic injection, Others)
- Vaginal Laser Treatment (MonaLisa Touch)

#### OTHERS

- Painful Urination, Frequent Urination, Blood in Urine
- Urinary Leakage
- Cold (Symptoms: )
- Vaccinations
- Vaginal Laser Treatment
- Others ( )

## SCREENING TEST HISTORY ※

1. Have you ever had cervical cancer screening tests? Year \_\_\_\_ Month \_\_\_\_
2. Have you ever had uterine cancer screening tests? Year \_\_\_\_ Month \_\_\_\_
3. Have you ever had pelvic ultrasound exams? Year \_\_\_\_ Month \_\_\_\_
4. Have you ever had blood tests? Year \_\_\_\_ Month \_\_\_\_
5. Have you ever had mammary gland ultrasound exams? Year \_\_\_\_ Month \_\_\_\_
6. Have you ever had mammography? Year \_\_\_\_ Month \_\_\_\_

## MENSTRUAL HISTORY

1. Date of your last period. ※ → (Y \_\_\_\_ M \_\_\_\_ D \_\_\_\_ for \_\_\_\_ days) (prior to that: Y \_\_\_\_ M \_\_\_\_ D \_\_\_\_ )
2. When was your menopause? ( \_\_\_\_ years old)
3. Menstrual Cycle  Normal ( \_\_\_\_ ) days long,  Irregular ( \_\_\_\_ ~ \_\_\_\_ ) days long

## PREGNANCY AND CHILDBIRTH

1. Are you sexually active? ※  No  Yes
2. Have you ever been pregnant? ※  No  Yes

Date of Childbirth	Condition of Pregnancy and Childbirth	Birth Weight	Condition of Infant	Hospital Name
① Y ____ M ____ D ____	<input type="checkbox"/> Normal <input type="checkbox"/> C-Section <input type="checkbox"/> Miscarriage <input type="checkbox"/> Stillbirth <input type="checkbox"/> Abortion ( ____ weeks)	g		
② Y ____ M ____ D ____	<input type="checkbox"/> Normal <input type="checkbox"/> C-Section <input type="checkbox"/> Miscarriage <input type="checkbox"/> Stillbirth <input type="checkbox"/> Abortion ( ____ weeks)	g		
③ Y ____ M ____ D ____	<input type="checkbox"/> Normal <input type="checkbox"/> C-Section <input type="checkbox"/> Miscarriage <input type="checkbox"/> Stillbirth <input type="checkbox"/> Abortion ( ____ weeks)	g		

3. Have you had any complications during childbirth? ( )