

**For Patients Visiting the the Department of Intergrated Women's Health**

|  |  |
| --- | --- |
| Name : | Age : |
| Height： cm | Weight : kg |
| Email address : | Tel： |

1. **Please tell us the purpose of your visit today.** 
   * Menstrual abnormalities → ☐ Never menstruated ☐ Menstruation stopped over time ☐ Irregular menstruation ☐ Heavy menstruation ☐ Light menstruation ☐ Strong pain
   * Irregular bleeding ☐ Abdominal pain ☐ Lower back pain ☐ Abnormal discharge (☐ Large amount
   * Colored ☐ Off-smelling)
   * Fibroids ☐Ovarian cystoma ☐Endometriosis ☐ Genital abnormalities ☐ Possible cancer
   * Lowered uterus ☐ Sexually-transmitted infections ☐ I want to have children.
   * Consultation on contraceptives
   * Menopausal symptoms (Specific symptoms: )

☐Other/I want to discuss my progress or other matters

1. **Please tell us about your menstruation.**

First period: Around years old Menopause: Around years old

Most recent period: Started on (YYYY) (MM) (DD) and lasted days Menstrual cycle (Number of days from the day your period starts until the day your next period starts):

-day cycle / Lasts days

When early, it comes around the (DD) . When late, it comes around the (DD) . (Regular / Irregular) Pain (severe / mild / none) Amount (heavy / normal / light)

1. **Do you have any allergies?** ☐ No ☐ Yes

Medication: Foods: Other (Latex, pollen, etc.):

What symptoms did you develop and at around what age?

1. **Please tell us about your pregnancy/childbirth history.**

\*Have you ever had sexual intercourse? ☐ Yes ☐ No \*Have you ever been pregnant? ☐ Yes ☐ No

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Year and outcome of past births/miscarriages | | Weeks at gestation  during birth | Delivery method | Complications | Children |
| Year | Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar  pregnancy | weeks | Vaginal (Epidural/vacuum/forceps)  Caesarean section  (Reason: ) | No / Yes  (  ) | Weight at birth: g  Sex: M / F Past/Current Illnesses: |
| Year | Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar  pregnancy | weeks | Vaginal (Epidural/vacuum/forceps)  Caesarean section  (Reason: ) | No / Yes  (  ) | Weight at birth: g  Sex: M / F Past/Current Illnesses: |
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| Year | Normal/preterm/ miscarriage/abortion/ ectopic pregnancy/Molar  pregnancy | weeks | Vaginal (Epidural/vacuum/forceps)  Caesarean section  (Reason: ) | No / Yes  (  ) | Weight at birth: g  Sex: M / F Past/Current Illnesses: |

1. **Please tell us about your partner and your family (excluding your children).**

\*Please include information regarding hypertension, diabetes, cancer, mental illness, and sudden death.

* + Not married ☐ To be married soon ☐ Married (Month Year: Age: )
  + Divorced (Year: Age: ) ☐ Widowed (Year: Age: )
  + Remarried (Month Year: Age: )
* Partner: years old (Occupation: ) ☐ Healthy/ Ill (Name of illness: )
* Father: years old ☐ Healthy ☐ Ill (Name of illness: )
  + - Estranged ☐ Deceased (Age: )
* Mother: years old ☐ Healthy ☐ Ill (Name of illness: )
  + - Estranged ☐ Deceased (Age: )
* Big brother / Big sister / Little brother / Little sister: years old

☐ Healthy ☐ Ill (Name of illness: ) ☐ Deceased (Age: )

* Big brother / Big sister / Little brother / Little sister: years old

☐ Healthy ☐ Ill (Name of illness: ) ☐ Deceased (Age: )

* Big brother / Big sister / Little brother / Little sister: years old

☐ Healthy ☐ Ill (Name of illness: ) ☐ Deceased (Age: )

1. **Please tell us about your history of illness.**（Including hypertension, diabetes, asthma, and other illnesses）

Year: Age: Name of illness: Current medications:

Year: Age: Name of illness: Current medications:

Year: Age: Name of illness: Current medications:

* Other medications/supplements:
* Have you ever had surgery? ☐ No ☐ Yes Year: Age:

Year: Age:

* Have you ever consulted with a psychological counselor, psychotherapist, or psychiatrist?

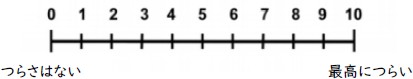
☐ No

* + Yes (When?: Reason: Name of clinic/hospital:
    - Forgotten)

1. **Please tell us about your lifestyle habits.**

* Smoking: ☐ I have never smoked.
  + I used to smoke but no longer do (From age \_ to age . \_ cigarettes per day)
  + I currently smoke (From age . cigarettes per day)
* Alcohol: ☐ I do not drink ☐ I drink: (Type: Amount: ml per day, \_\_\_\_\_times per week)
  + I stopped drinking after getting pregnant

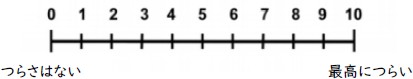
1. **Please circle the below number that best averages how difficult the past week has been for you.**



Not at all

Extremely

1. **To what extent did that difficulty affect your daily life?**



Not at all

Extremely

**Thanks for your cooperation!**