QUESTIONNAIRE: CENTER FOR GYNECOLOGIC ENDOSCOPY

Date: 20 yyyy/ mm/ dd

Name: ..... Age: ..... DOB: yyyy/ mm/ dd

Height: ..... cm Weight: ..... Kg Occupation: .....

Your emergency contact (mobile) number: ..... Your partner's age: .....

1. Purpose of visit Circle and describe as appropriate (mark all that apply)

(1) Recommended to have (laparoscopic/hysteroscopic) operation for (Myoma (Fibroid)/Endometriosis/ Ovarian cyst/Endometrial polyp/Other .....) at (.....) hospital/clinic.
(2) Having infertility treatments/testing at (.....) hospital/clinic.
(3) Other (.....)

→Please bring a referral, medical records and/or test results, if any, on your initial visit.

2. Marital status Circle, check and/or describe as appropriate

Married (at age .....) de facto marriage Planning to get married Single (Non virgin / Virgin)
Divorced → I have □ no child / □# ..... child(ren) Other (.....)

3. Menstrual history Circle and describe as appropriate

Age at first period ..... Age at menopause .....
Menstrual cycle ..... - ..... days (Avg. ..... days) Regular / Irregular / Other .....)
Bleeding usually lasts for ..... days Flow: (Heavy/Moderate/Light/Not sure)
Painful periods ? No/Yes →Pain in the (Lower abdomen/Lower back/Head/Other .....) Severity: (+/++/+++)
Last menstruation: from mm/ dd to mm/ dd (..... days)

4. Obstetric history Please fill in the following

# of Total Pregnancies ..... #Total Deliveries ..... (→#Vaginal Deliveries ..... #C-Sections .....)
# of Stillbirths ..... # of Miscarriages ..... # of Artificial Abortions .....
#of Ectopic pregnancies ..... (Right tube/Left tube/ Other ...../Unknown) #Hydatidiform moles .....

↑ Pregnancies outside the uterus

5. Gynecological history Have you ever diagnosed or treated with the following? (No/Yes)
→If Yes, check, circle and describe

□ Abnormal PAP smear (cervical cancer screening) result(s)
→(No hospital visit at the moment / Visiting a doctor regularly) at ..... Hospital
□ Diagnosed with Myoma(Fibroid)/Endometriosis/ Ovarian cyst/Endometrial polyp/ Uterine adenomyosis/Chlamydia infection/ Other .....

And
- ・Had a surgery →(Operative method .....) in (yyyy/ mm) at (..... Hosp)
- ・Had (Name of treatment .....) ・Under watchful waiting / follow-up.
- ・Other .....

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6. Past history other than Gynecology Check, circle and describe as appropriate

☐ Gastroenterology (Esophagus/Stomach/Bowel/Appendix) ☐ Respiratory (incl. Asthma)
☐ Cardiovascular (Heart/Blood Vessels) ☐ Liver/Gallbladder/Pancreas ☐ Kidney ☐ Hypertension
☐ Diabetes ☐ Thyroid ☐ Blood ☐ Rheumatoid/Collagen Disease ☐ Allergy ☐ Infectious Disease
☐ Urology ☐ Orthopedics ☐ Eye ☐ Skin ☐ Ear, Nose and Throat ☐ Neurosurgery ☐ Neurology
☐ Psychosomatic Med./Psychiatry ☐ Other .....

⇩Please fill in the details below

(1) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(name .....)(Hosp)

(2) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(name .....)(Hosp)

(3) Injury or disease ..... in (yyyy/ mm) at age ..... (Cured / Under treatment / Surgery)
Are you on medication? No / Yes→(name .....)(Hosp)

7. Social history, Allergy, Asthma and Blood transfusion Check, circle and describe as appropriate

Use of Alcohol ☐ No ☐ Yes (Everyday / 2-3 times a week / Occasionally) ☐ Used to drink
Smoking ☐ No ☐ Yes (..... cigarettes/day for ..... years) ☐ Used to smoke

Drug Allergy ☐ No ☐ Yes → (Name .....)
Food Allergy ☐ No ☐ Yes → (Name .....)
Other Allergy ☐ No ☐ Yes → (Name .....)

Asthma ☐ No ☐ Yes → (Only in my childhood, not now /No symptoms now/Under treatment)
Last asthma attack in (yyyy/ mm)
Treated with (medicine .....) at (Hosp)

Blood transfusion ☐ No ☐ Yes → in (yyyy/ mm) at age ..... for (reason .....)

6. Family history If your blood family has/had any of the following, please check, circle and describe

☐ Father Hypertension/Diabetes/Cancer (Specify .....)
☐ Mother Hypertension/Diabetes/Cancer (Specify .....)
☐ Older/Younger Brother/Sister Hypertension/Diabetes/Cancer (Specify .....)
☐ Grandpa Hypertension/Diabetes/Cancer (Specify .....)
☐ Grandma Hypertension/Diabetes/Cancer (Specify .....)

Please describe your comments and request freely.

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Thank you for your cooperation. Please present this sheet on your consultation.

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