Questionnaire: Human Reproduction and Gynecologic Endoscopy (Gynecology)

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. What made you decide to visit our hospital? Please circle all that apply.

(1) Internet (choose 1 from a – e)
a. Advertising site b. our website c. YouTube d. TikTok e. Instagram f. X (formerly Twitter)
(2) Recommended from family, acquaintance, or friend (3) Referred from another medical institution
(4) Other ( )

2. 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.

3. 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 ( )

4. 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/Unsure)
Painful periods ? No/Yes →Pain in the (Lower abdomen/Lower back/Head/Other) Severity: (+/++/+++)
Last menstruation: from mm/ dd to mm/ dd (days)

5. 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 /Unsure) #Hydatidiform moles

↑ Pregnancies outside the uterus

6. 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 observation/follow-up
・Other

Center for Hunan Reproduction and Gynecologic Endoscopy
Women's Medical Center, Sanno Hospital

7. 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)

8. 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 .....)

9. 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 feel free to write down any opinions or wishes you have regarding surgery or hospital visits.

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