Obestetric questionnaire Please fill in this form in as much detail as possible for better diangnosis.

Date : Year 20____Month_____Day_____ Name : _____

【1、Confirmation of pregnancy】Please choose from ①~④－－－－－－－－－－－－－－－－－－－－－－－－

□ **①Natural pregnancy** □ **②Timing therapy**

・When was your last menstruation? : From Month_____Day_____ for _____days

・Did you check using an over the counter pregnancy test? Date of positive reaction : Month____Day____

・Day of ovulation : □Do not know □Basal body temperature table→Please show us the table.

□Date of positive reaction of ovulation test : Month_____Day_____←Date of the most strong reaction

Please inform us the name of the hospital,if you have received a pregnancy diagnosis from another hospital : (Name of hospital :)

⇒Expected date of delivery : Month_____Day_____

(Calculated from □Last menstruation □Ovulation date □Do not know □Other)

□ **③Artificial insemination** When is your delivery date? : Month_____Day_____

□ **④In vitro fertilization** Day of transplantation : □ D3 □ D5

When is your delivery date? Month_____Day_____ □ IVF □ ICSI

【2、About delivery】Please choose from ①～③－－－－－－－－－－－－－－－－－－－－－－－－－－－－

□ **①Give birth** : Delivery location

(This clinic ・ Back home ・ Other hospitals ・ Maternity hospital ・ Home ・Undecided)

・Do you have a mother and child health handbook? (Yes・No) If yes,please submit it to the reception.

・Please inform us the name of the hospital if you have already decided on another hospital.
( )

・Please tell us the reason you have chosen Ikuryo Clinic. ↴
( )

□ **②Have an abortion** : Have you already discussed and agreed on this decision with your partner?

(Yes・No) Reason of abortion: (□ Mental reasons □ Economic reasons □ Medical reasons)

□ **③Undecided or under consideration**

【3、About consulting Ikuryo Clinic】－－－－－－－－－－－－－－－－－－－－－－－－－－－－－－－－

① Have you read our medical philosophy on our homepage? (Yes・No)

② Please tell us where you learned about Ikuryo clinic.
Introduction from friend or an acquaintance (Who?)、Introduction from other hospitals (Name of hospital:)、Because it was near workplace or home、Internet、 Book or magazine ( )、Other ( )

③ Do you have any symptoms you are worried about now? (Ex. Bleeding、stomachache、itchiness、urination problems) ⇒Please inform us in detail ( )

④ Please tell us about your spouse/partner.
Age : _____ years old Profession : ( )
Nationality : (Japan・Other ➡) Is he in good health? : (Yes・No)

◎Please check the applicable box and fill in the brackets below. **Name:** 受-67 English

・Height (　　)cm ・ Weight (　　)kg ←Weight before pregnancy, if pregnant

・First menstruation (　　)years old

・Menopause (　　)years old

・Cycle of menses : Days of the first day of menstruation to the first day of your next menstruation

☐Regular (　　)days

☐Irregular (　　)days to (　　)days

Occupation:

・Have you experienced sexual intercourse before? ☐No ☐Yes

・Have you ever had gynecological examination before? ☐No ☐Yes

・Marital status ☐Not married ☐Married at age (　　) ☐Divorced at age (　　)

・Are you allergic to any medication? ☐No ☐Yes (　　)

・Do you have any food allergy? ☐No ☐Yes (　　)

●Please inform us about your pregnancies until now. If zero, please write 0.

Pregnancy(　　)times　Delivery(　　)times　Miscarriage(　　)times　Abortion(　　)times　Other(　　)

	Year/Month/Day	Age	Week	Baby weight(g)	Sex	Health	Delivery method	Miscarriage or abortion	Hospital	Other
Ex.	2011/12/9	27	39	3120	F	Good	Vacuum extraction Caesarean section		Ikuryo Clinic	Labor intruduction

●Please check the applicable box below about your medical conditions and lifestyle habits, and write the age, method of treatment (internal medicine, surgery etc.) ,name of hospital in the brackets below.

☐Endometriosis ☐Fibroids・Gland fibroids ☐Ovarian tumor ☐STD(Sexually transmitted disease) ☐Mental illness

☐High blood pressure ☐Diabetes ☐Brain disease ☐Glaucoma ☐Thyroid disease ☐Asthma ☐Autoimmune disease

☐Cancer ☐Surgical history ☐Hospital admisssion history ☐Drinking habit ☐Smoking ☐Currently taking medicine ☐Other

[　　]

●Family diseases Please write the relationship to you in the brackets(　) ex.☑Cancer (Grandfather)

☐High blood pressure (　　) ☐Diabetes (　　) ☐Cancer (　　) ☐Other (　　)

●Have you had a cervical cancer screening within 1 year? ☐No ⇒ Do you have any plans to have one in the near future? ☐No ☐Yes

☐Yes ⇒When？Year(　　)Month(　　) ⇒Result ☐Normal ☐Abnormal

●Have you had a rubella antibody test? ☐Yes ☐No →(Residence is in ☐Meguroku ☐Other)