Gynecological Questionnaire

date of entry ______________________

name : ______________________ age : ________ birthday : ____ / ____ / ____

Purpose of visit (multiple answers allowed)

- ☐ Cervical cancer screening
- ☐ Trouble with menstruation (irregular, painful or heavy menstruation, or others)
- ☐ Itching in the pubic area
- ☐ Irregular bleeding
- ☐ Abnormal vaginal discharge
- ☐ Abdominal pain
- ☐ Menopausal symptoms
- ☐ I would like to consult about pills
- ☐ Other（ ）

About menstrual condition

1． When was your last menstrual period?
   - the date it started (day/ month/ year)
   - the date it ended (day/ month/ year)
2． At what age did your first menstruation come? (years old)
3． At what age did you reach menopause? (years old)
   ※ only for post-menopausal woman
4． How long is your menstrual cycle?
   normal（ days） ・ irreguar（ ～ days）
5． How heavy is your menstrual pain heavy ・ normal ・ light ・ no pain
6． How heavy is your flow? heavy ・ normal ・ light

Please tell us about your condition

1. Number of pregnancies and deliveries?
   - Pregnancy（ times） ・ Delivery（ times）
2. Are you married ? yes ・ no
3. Do you have experience of sexual intercourse? yes ・ no
4. Are you taking pills or other hormone drugs? yes ・ no
5. Are you allergic to any medications or foods？ yes ・ no
   drug/food : ______________________ symptoms : ______________________

Please tell us about your medical history

- Uterus/Ovary : no ・ yes （ovarian cyst、fibroid、endometriosis、others）
- Other diseases : ______________________

Please tell us when you had your recent checkup

- （ month/ year）; cervical cancer screening・ultrasonogaraphy
- I have never had a uterine cancer screening before