Obstetrical Patient Questionnaire

Please take the time to fill out the questionnaire .
If you are unsure of the answers, leave the spaces blank. We will assist you to complete the form.

Date: (Month)_____ /(Day)_____ /(Year)_____

Name: (First)_____ **(Middle)**_____ **(Last)**_____**ID No.**_____
(if applicable ,write the name as in your Japanese family register)

Date of Birth: (Month)_____ **/(Day)**_____ **/(Year)**_____ **(Age you became pregnant:_____years old)**

- What are the reasons for your visit to our hospital? *(Please check all that apply)*
  - ☐ Pregnancy test was positive. (Date: (Month)_____ /(Day)_____ /20_____)
  - ☐ For regular medical check-up at this hospital
  - ☐ For medical check-up (Plan to deliver at a birthing center or at home)
  - ☐ For delivery at this hospital
  - ☐ "Open System" (Check-up: neighboring clinic Delivery: our hospital by your general practitioner/midwife)
  - ☐ "Semi-open System" (Check-up: neighboring clinic Delivery: our hospital)
  - ☐ For second opinion (Reason:)
  - ☐ Other reason (Specify:)

- Have you visited our hospital before? (e.g. on [date], I was diagnosed as pregnant at [name of clinic])

  ☐ First Visit ☐ Referred No / Yes

- Have you had any major **illness** in the past? No / Yes
  If **YES**, when (date or age) / diagnosis / medical treatment / name of hospital

- Have you had any surgical **operations** in the past? No / Yes
  If **YES**, when (date or age) / diagnosis / surgical procedure / name of hospital

- Please complete the following information about <u>you</u>.

  Current address (〒_____)

  Home phone # (_____) Mobile phone # (_____)

  Current occupation (_____)

  Nationality (_____) Religion (_____)

- Person to contact in case of emergency

Name	Phone number	Relationship
		Partner / Family / Partner's work phone
		Partner / Family / Partner's work phone

- Please complete the following information about <u>your partner</u>.

  Name: ((First) (Middle) (Last))

  Age: (_____ years old) Nationality: (_____) Occupation: (_____)

  Physical condition: Good / Not good (Reason:_____) Blood type: (_____)

- Your **height**: (_____)cm Your **weight** before pregnancy: (_____)kg

- Menstrual history
  Age at first period (_____) years old
  How often do you get your menstrual cycle? Every (_____) days, lasting (_____) days
  Your menstrual cycles are: Regular / Irregular

※Last period was (Month) /(Day) / 20 ～ (Month) /(Day) / 20 (days)

※Do you know your due date? No / Yes ((Month) /(Day) / 20)

- Have you had infertility treatment? No / Yes
  If **YES**, when (date or age) / type of treatment / name of hospital

- History of previous pregnancies

(Pregnancy: times Delivery: times Miscarriage: times Abortion: times)

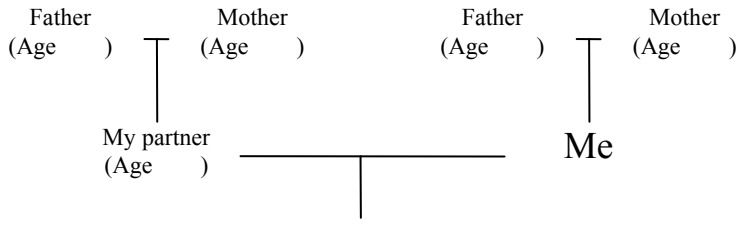
Birth date	Your age	Weeks	Baby's sex	Baby's weight	Type of delivery/miscarriage	Length of labor	Complications during delivery / treatment after miscarriage	Location	Type of feeding

- Are you married? No / Yes
  If **NO**, Do you plan to get married with the partner? No / Yes (When? _____)
  If **YES**, How old were you when you got married? (_____ years old) Do you have different family name? No / Yes

  Are you and your partner related by blood? No / Yes

- Do you smoke cigarettes? No / Yes (How many pieces? _____pieces/day)
  Did you smoke in the past? No / Yes (from ____ years old to ____ years old, _____pieces/day)
- Do you drink alcohol? No / Yes (What kind?_____ how much? _____)
- Are you currently taking any medications? No / Yes (What?_____ from when?_____)
- Have you had any blood transfusion? No / Yes (When?_____ Why? _____)
- Do you have any allergies to medications? No / Yes (What?_____ Reactions:_____)
- Do you have any allergies to food? No / Yes (What?_____ Reactions:_____)
- Do you have other allergies? No / Yes (What?_____ Reactions:_____)

- Please complete the family tree:
  1) Fill out ages 2) Circle those you live with



- Family history

Diabetes	No	/	Yes	(Who?_____)
Hypertension	No	/	Yes	(Who?_____)
Breast cancer	No	/	Yes	(Who?_____)
Deafness *(NOT the age-related)*	No	/	Yes	(Who?_____)
Neurological disease *(e.g. epilepsy)*	No	/	Yes	(Who?_____)
Others	(Specify: _____)			

- Your residence after discharged from the hospital: Home Parent's Home Other (Specify_____)

Thank you for taking the time to complete this questionnaire. The information you provided will be shared between our staff for purposes of your examination in clinic and during hospitalization. We are committed to using all reasonable efforts to keep your personal information confidential.

(For our use: Date of confirmation / Signature)