ENA YAMASHITA WOMEN'S CLINIC
ENA 山下ウィメンズクリニック

Pre-consultation Interview Sheet

Check ☑ where applicable and answer the questions below Date: (dd)/ (mm)/ (yy)ID

Name(wife)		Name(husband)	
Birthday and Age	(dd)/ (mm)/ (yy) years old	Birthday and Age	(dd)/ (mm)/ (yy) years old
Job title			
Address			
Mobile phone number/ Home telephone number	/		
Mobile phone mail address	@		
□docomo.ne.jp □softbank.ne.jp □ezweb.ne.jp □i.softbank.jp □k.vodafone.ne.jp □gmail.com □other			

1) What is your problem?

□Infertility →How long have you tried to have a baby? (mm) (yy)

□In vitro fertilization □Recurrent miscarriage □Introduction from urologist □Cancer check or vaccine

□Second opinion □Other gynecological problem( )

2) Menstruation

✧ First period started at years old

✧ Last menstruation started at (dd) (mm) and lasted for days

✧ Previous menstruation above started at (dd) (mm) and lasted for days

✧ Menstruation cycle: □ Regular (days) □ Irregular ～ (days)

✧ Any symptoms with menstruation: □Lower abdominal pain □Lower back pain □Headache □Other

✧ Do you use a painkiller for these symptoms? □Yes □No

3) Marital status

□Married (mm) (yy) □Divorced (mm) (yy) □Remarried (mm) (yy) □Single

4) Your history of pregnancy and the result

1. Age: (Delivery/ Cesarean section / Miscarriage / Abortion / Ectopic pregnancy) (week) ♀/ ♂(g)
2. Age: (Delivery/ Cesarean section / Miscarriage / Abortion / Ectopic pregnancy) (week) ♀/ ♂(g)
3. Age: (Delivery/ Cesarean section / Miscarriage / Abortion / Ectopic pregnancy) (week) ♀/ ♂(g)
4. Age: (Delivery/ Cesarean section / Miscarriage / Abortion / Ectopic pregnancy) (week) ♀/ ♂(g)

☺Please check the other side of this paper

5) Body weight etc, Diseases and Allergies

✧ Height _____ cm ✧ Weight____ kg ✧ Blood type A B O AB （Rh ＋/ －）

✧ Tobacco □ Non-smoker/□ Smoker （ ）/day

✧ Sexual intercourse □Yes/ □No →(If no) Do you want to have a vaginal examination? □Yes/ □No

✧ Diseases

□No □Asthma (Last attack at ____ years old) □Uterus myoma □Endometriosis

□Adenomyosis □Ovarian tumor(chocolate cyst/ dermoid/ other) □Cancer( )

□Heart □Liver □Kidney □Infection(HIV/ Treponema / Hepatitis A type/ B type/ other)

□Operation(s)( )

✧ Drugs(daily use or occasional) name:_____

✧ Supplementary or Chinese medicine：_____

✧ Any side effects or allergies? □No /□Yes:_____

6) Your partner

✧ Tobacco □No- smoker/ □Smoker （ ）/day

✧ Any major diseases? □No /□Yes:

✧ Height _____ cm ✧ Weight_____ kg

Check ☑ and write the results of your previous examinations

Examination	Date: ____(mm) ____(yy)	Institution	Result	
□Hormone level(blood test)			Normal	Abnormal(Detail:)
□Hysterosalpingography			Normal	Stenosis /Obstruction/R/L
□Hysteroscopy			Normal	
□Semen analysis			Normal	
□Huner test			Normal	
□Chlamydia test			Negative	After / Before: treatment
□Cervical cancer test			Normal	After / Before: treatment
□Recurrent miscarriage test			Normal	After / Before: treatment

Previous treatment

□Natural timing x _____ cycles The last day of this treatment:_____(mm) _____(yy)

□IUI x_____ cycles The last day of this treatment:_____(mm) _____(yy)

☺Thank you for your cooperation. Your personally identifiable information is safeguarded in our clinic.