Patient Medical History Form

Chart No.	

くすの木
レディースクリニック
北千住

Today's date: [year] [month] [day]

Patient name: [Last] [First] [Middle (initial)]

Date of birth: [year] [month] [day] Age: Sex: F / M / Other

Occupation: Blood type: [ABO] A / B / O / AB [Rh] ＋ / －

Height: (cm) Weight: (kg)

Address: [Street]

[City] [State] [Country] [Zip]

Phone: [Home] [Mobile]

E-mail (if available):

Reason(s) for Today's Visit:

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1. Are you currently pregnant?

☐ No

☐ Yes ◆How far ? Weeks Days

◆Expected Due Date Year 20 / Month / Day ☐I do not know ☐may change later

◆Last menstrual period: from Year 20 / Month / Day for days ☐cannot remember

◆Number of fetus(es) ☐ singleton ☐ twins ☐ other ( )

◆Your obstetric clinic ( ) ◆Your primary obstetrician ( )

※ We will not directly contact with your obstetric clinic without notifying you.

2. How did you get pregnant?

☐Naturally

☐With fertility treatment assistance ◆ Your fertility Clinic ( )

☐Timing of ovulation was told ◆ Ovulation inducer (ovarian stimulation drug) was used ☐No ☐Yes

☐Intrauterine insemination ◆ Ovulation inducer (ovarian stimulation drug) was used ☐No ☐Yes

☐Conventional IVF ◆ Ovulation inducer (ovarian stimulation drug) was used ☐No ☐Yes

☐ICSI ◆ Frozen embryo was used ☐No ☐Yes → transferred day ( ) embryo

◆ Egg retrieval date: Year 20 / Month / Day Embryo transfer date: Year 20 / Month / Day

Was donor's egg/sperm/embryo used?

☐No

☐Egg donation ◆ Donor's date of birth Year /Month /Day ◆ Donor's age

◆ Frozen embryo was used ☐No ☐Yes → transferred day ( ) embryo

◆ Egg retrieval date: Year20 / Month / Day Embryo transfer date: Year20 / Month / Day

☐Embryo donation ◆ Donor's date of birth Year /Month /Day ◆ Donor's age

◆ Frozen embryo was used ☐No ☐Yes → transferred day ( ) embryo

◆ Egg retrieval date: Year20 / Month / Day Embryo transfer date: Year20 / Month / Day

☐Sperm donation

◆ Any other comments and concerns that you would like to tell us

( )

3. Have you had (or will you have) any prenatal testing (fetal assessment) with this pregnancy?

☐No

☐Yes, I had. ☐Yes, I will. ◆ please check all that apply.

☐first trimester screening ☐NT measurement ☐NIPT or cell-free DNA testing

☐2nd trimester serum screening or quad (quadruple) test ☐2nd trimester detailed ultrasound

☐CVS ☐amniocentesis ☐Other ( )

◆ Name(s) of the clinic(s) performed the test(s) above ( )

◆ Result(s) of the test(s) you have already had ( )

4. Pregnancy history

A) Pregnancy

◆Past pregnancy: how many times? (not including current one)

◆number of spontaneous abortion ◆number of ectopic pregnancy

◆number of termination ◆number of still birth ◆other

Year/Month/Day	Outcome	Weeks	Sex	Clinic name
	Spontaneous abortion / ectopic / termination/ still birth / other		M/F/Unknown	
	Spontaneous abortion / ectopic / termination/ still birth / other		M/F/Unknown	
	Spontaneous abortion / ectopic / termination/ still birth / other		M/F/Unknown	
	Spontaneous abortion / ectopic / termination/ still birth / other		M/F/Unknown	
	Spontaneous abortion / ectopic / termination/ still birth / other		M/F/Unknown	

B) Delivery

Year/Month/Day	Caesarean section	Weeks	Sex	Birth weight	Clinic name	Medical condition(s), if any
	Yes / No		M/F/Unknown	g		
	Yes / No		M/F/Unknown	g		
	Yes / No		M/F/Unknown	g		
	Yes / No		M/F/Unknown	g		

5. Marital status and your partner's information

◆Your partner's name （ ）

◆Your partner's age ◆Your partner's occupation （ ）

◆Are you and the father of the baby related with each other (blood relatives)?

☐No ☐Yes → relationship （ ）

◆Are you married? ☐Yes ☐No ☐Other （ ）

6. Ethnic backgrounds ※ please check all that apply

◆You ☐Caucasian ☐Jewish ☐African ☐East-Asian (Japanese, Korean, Chinese)
☐other Asian ☐Other （ ）

◆father of the baby ☐Caucasian ☐Jewish ☐African ☐East-Asian (Japanese, Korean, Chinese)
☐other Asian ☐Other （ ）

7. Result(s) of the past genetic testing and/or chromosomal analysis with previous pregnancy, previous children, you, your partner, family members of you and your partner

☐None

☐Yes ◆Who （ ） had (test name), and the result was （ ）
◆Who （ ） had (test name), and the result was （ ）
◆Who （ ） had (test name), and the result was （ ）

8. Anyone who have(had) birth defects/genetic conditions/other major medical conditions? (you, your partner, and blood relatives of you and your partner, previous children)

☐None

☐Yes ◆who（　　）have(had) condition(s)（　　）
◆who（　　）have(had) condition(s)（　　）
◆who（　　）have(had) condition(s)（　　）
◆who（　　）have(had) condition(s)（　　）

9. Do you have any allergy?

☐No

☐Yes ◆I am allergic to（　　）

10. Your medical conditions and surgical history

A) Major medical conditions

☐None

☐I have(had)
- ☐hypertension ◆treatment ☐None ☐Yes（　　）
- ☐diabetes ◆treatment ☐None ☐Yes（　　）
- ☐other（　　）
  ◆treatment ☐None ☐Yes（　　）

B) Surgical history

☐None

☐I had （　　）at age
（　　）at age

11. Current medication

☐None

☐I am taking（　　）

12. Do you smoke?

☐No

◆Past smoking history ☐None

☐Yes
- ☐quit before this pregnancy ◆from age　until age　◆how many?　／day
- ☐quit after finding this pregnancy ◆from age　until age　◆how many?　／day

☐Yes I am currently smoking ◆from age　until age　◆how many?　／day

13. Do you drink alcohol?

☐No → ◆Past drinking ☐None ☐Yes

☐Yes

14. How did you get to know our clinic?

☐website ☐TV・books・journals・other media（Please specify　　）

☐from friends ☐from family members ☐from the other clinic ☐other（　　）

Thank you very much. Please give this form to our receptionist.

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