Name: _____ Date of birth:_____

Last **First** **Middle** M D Yr

Address:〒 _____

Telephone: Home_____ Office_____ Emergency_____

Your or your husband's occupation: _____

Place of employment:_____

Height:_____ Weight:_____

1. Your problem or reason for this visit:_____
2. How long have you had this problem?_____
3. When was your last period? From_____ To_____
4. What is your menstrual cycle? 25_____28_____30_____Irregular_____
5. Are you married? Yes_____ No_____
   If yes, how old were you when you got married? Age_____
   If not married, do you have sexual intercourse experience? Yes_____ No____
   If not married, do you have a sexual intercourse partner? Yes_____ No_____
6. Have you ever become pregnant? Yes_____ No_____
   If yes, how many times? 1_____2_____3_____Or more_____
7. Have you ever delivered baby? Yes_____ No_____
   If yes, 1st baby in _____Yr 2nd baby in _____Yr 3rd baby in _____Yr
8. Method of delivery: Natural_____ C/S_____
   Other_____
9. Have you ever had a miscarriage or termination? Yes_____ No_____
   If yes, miscarriage in _____Yr termination in _____Yr
10. Are you taking contraceptive pills now? Yes_____ No_____
    If yes, how long?_____ If you have taken before, when?_____
11. Medical history_____
12. Family history_____
13. Drug allergy: Yes____ No_____ Name of drug_____
14. Current medication (including over-the-counter drugs)

    _____

Referred to us by:_____

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