

SYMPTOMS SINCE LMP

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GENETIC SCREENING/TERATOLOGY COUNSELING					
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:					
	YES	NO		YES	NO
1. PATIENT'S AGE ≥ 35 YEARS AS OF ESTIMATED DATE OF DELIVERY			12. HUNTINGTON'S CHOREA		
2. THALASSEMIA (ITALIAN, GREEK, MEDITERRANEAN, OR ASIAN BACKGROUND): MCV <80			13. MENTAL RETARDATION/AUTISM		
3. NEURAL TUBE DEFECT (MENINGOMYELOCELE, SPINA BIFIDA, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4. CONGENITAL HEART DEFECT			14. OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5. DOWN SYNDROME			15. MATERNAL METABOLIC DISORDER (EG, TYPE 1 DIABETES, PKU)		
6. TAY-SACHS (EG, JEWISH, CAJUN, FRENCH CANADIAN)			16. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
7. CANAVAN DISEASE			17. RECURRENT PREGNANCY LOSS, OR A STILLBIRTH		
8. SICKLE CELL DISEASE OR TRAIT (AFRICAN)			18. MEDICATIONS (INCLUDING SUPPLEMENTS, VITAMINS, HERBS OR OTC DRUGS)/ILLCIT/RECREATIONAL DRUGS/ALCOHOL SINCE LAST MENSTRUAL PERIOD		
9. HEMOPHILIA OR OTHER BLOOD DISORDERS			IF YES, AGENT(S) AND STRENGTH/DOSAGE		
10. MUSCULAR DYSTROPHY			19. ANY OTHER		
11. CYSTIC FIBROSIS					

COMMENTS/COUNSELING _____

INFECTION HISTORY	YES	NO		YES	NO
1. LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			4. HISTORY OF STD, GONORRHEA, CHLAMYDIA, HPV, SYPHILIS		
2. PATIENT OR PARTNER HAS HISTORY OF GENITAL HERPES			5. OTHER (See Comments)		
3. RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD					

COMMENTS _____

INTERVIEWER'S SIGNATURE _____

INITIAL PHYSICAL EXAMINATION							
DATE	HEIGHT		BP				
1. HEENT	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	12. VULVA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> CONDYLOMA	<input type="checkbox"/> LESIONS	
2. FUNDI	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	13. VAGINA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> DISCHARGE	
3. TEETH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	14. CERVIX	<input type="checkbox"/> NORMAL	<input type="checkbox"/> INFLAMMATION	<input type="checkbox"/> LESIONS	
4. THYROID	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	15. UTERUS SIZE	_____ WEEKS		<input type="checkbox"/> FIBROIDS	
5. BREASTS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	16. ADNEXA	<input type="checkbox"/> NORMAL	<input type="checkbox"/> MASS		
6. LUNGS	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	17. RECTUM	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL		
7. HEART	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	18. DIAGONAL CONJUGATE	<input type="checkbox"/> REACHED	<input type="checkbox"/> NO	_____ CM	
8. ABDOMEN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	19. SPINES	<input type="checkbox"/> AVERAGE	<input type="checkbox"/> PROMINENT	<input type="checkbox"/> BLUNT	
9. EXTREMITIES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	20. SACRUM	<input type="checkbox"/> CONCAVE	<input type="checkbox"/> STRAIGHT	<input type="checkbox"/> ANTERIOR	
10. SKIN	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	21. SUBPUBIC ARCH	<input type="checkbox"/> NORMAL	<input type="checkbox"/> WIDE	<input type="checkbox"/> NARROW	
11. LYMPH NODES	<input type="checkbox"/> NORMAL	<input type="checkbox"/> ABNORMAL	22. GYNECOID PELVIC TYPE	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

COMMENTS (Number and explain abnormal) _____

EXAM BY _____

TOKYO MEDICAL & SURGICAL CLINIC

J.H.T. MARSHALL, M.B., B.S., M.R.C.P. (U.K.)
K. FUJII, M.D., F.A.C.S.
P. SEEZ, M.D., Ph.D.BDI (FRG)
H. SAKAMOTO, M.D., Ph. D., FJCOG, IFACOG
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32 SHIBA KOEN BUILDING, 3-4-30, SHIBA KOEN, MINATO-KU, TOKYO, 105-0011
<http://www.tmsc.jp>

TEL : 3436-3028
FAX : 3436-5024

Dr.Sakamoto's Fee

Normal Delivery:

Delivery Fee	¥300,000.- up
Epidural anesthesia	¥120,000.- up

Caesarian Delivery:

Surgeon's Fee	¥350,000.- up
Assistant Surgeon's Fee	¥ 80,000.- up
Anesthesiologist's Fee	¥ 80,000.- up

Gynecologic Surgical Procedures:

Surgeon's Fee	¥200,000.- up
Assistant Surgeon's Fee	¥ 80,000.- up
Anesthesiologist's Fee	¥ 80,000.- up

Please note that you will receive two bills:

- 1) For Dr. Sakamoto's fee (see above) from our accounting desk
- 2) For hospital fees from the hospital directly

Please prepare two payment guarantee forms with your insurance company.

The above costs may change depending on the nature of the medical procedures required.

I agree to the above.

Patient's signature

Date

Patient's name (print)

09/10/30

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