Medical Questionnaire

Name _____, Nationality _____

Date of Birth _____Year/_____Month/_____Day, Age_____,

Gender (Male ・ Female)

Address 〒 _____

Mobile phone _____—_____—_____

Height_____cm , Body Weight_____kg

・Do you have a referral document or letter ? （ Yes ・ No ）

・Do you agree to obtain medical information with your individual Number Card health insurance card? （ Yes ・ No ）

・What symptoms do you have? Please check the symptoms that apply to you.

Fever ・ Cough ・ Phlegm ・ Runny nose/Stuffy nose ・ Difficulty breathing
Sore throat ・ Palpitation ・ Shortness of breath ・ Dizziness ・
Freaquent urination ・ Weight loss ・ Feel thirsty ・ Hypertension ・ Paralysis ・
Swelling ・ Hives ・ Insomnia ・ Numbness ・ Diarrhea ・ Pain
Have no appetite ・ Nausea ・ Vomiting ・ Constipation ・ Dizziness ・ Itchiness
I was advised by another clinic/hospital to come here.
other (_____)

・Since when have you had these symptoms? _____

・Private medical care （Low doses contraceptive pill ・ Period control ・
Various injections for anti-aging ・ Erectile Dysfunction ・ AGA ）
other (_____)

・Are you currently undergoing treatment for any disease or had any medical conditions in the past? For patients who have agreed to obtain information through their Individual Number Card Health insurance card, description can be omitted. （ No ・ Yes ）

If you answered yes, please answer below.

Diabetes ・ Hypertension ・ Asthma ・ Heart disease ・ Arrhythmia

Atopic dermatitis ・ Gout ・ Cerebral hemorrhage/Cerebral infarction ・ Cancer

other (_____)

・Have you ever had a serious illness requiring hospitalization or surgery ?

（ No ・ Yes ）

・Do you smoke regularly ? （ No ・ Yes ・ Used to smoke ）

Cigarette consumption ___cigarettes/Day

Duration of smoking___Year, Year when you stopped smoking _____/_____

・Do you drink regularly ? （ No ・ Yes ）

□Beer _____ml/Day

□Whisky _____ml/Day

□Wine _____ml/Day

□Japanese sake _____ml/Day

□Other _____ _____ml/Day

・Are you currently taking any medication?（ No ・ Yes ）

・Are you allergic to any foods or medication ?（ No ・ Yes ）

If you answered yes, please write the name of allergen.

(_____)

・Questions for women.

Are you pregnant? （ No ・ Yes ）

Are you breastfeeding? （ No ・ Yes ）

・How did you know about our clinic ?

Referred from other institutes ・ Friend or relatives ・ Websites (Internet) ・

Newspaper, TV, Magazine ・ Other (_____)