Registration From 初診問診票

Date(yy/mm/dd): / /

Please write your name in カタカナ also, if you can.

Name

Birthday(yy/mm/dd) / / Sex M / F Do you have health insurance? Y / N

Address Phone

Nationality Language

＊What symptoms do you have? How long have you had them? どんな症状がありますか？それはいつからですか？

(fever ℃)

＊Have you seen another doctor for the symptoms? その症状について、他の医療機関を受診しましたか？

☐ No ☐ Yes (Which hospital or clinic?)

＊Do you have any disease under treatment or have you had in the past?
現在治療中もしくは過去に病気を患った事はありますか？

☐ No ☐ Yes (Age: Disease:)

＊Have you ever had any operation?
手術を受けたことはありますか？

☐ No ☐ Yes (Age: Reason:)

＊Have you ever had a blood transfusion? 輸血を受けた事はありますか？

☐ No ☐ Yes (Age: Reason:)

＊Are you allergic to any medication or food? 薬剤や食品でアレルギー反応が出たことはありますか？

☐ No ☐ Yes (Which Medicine or Food: 薬剤/食品名)
(What are the symptoms: 症状)

＊Do you have Asthma, Eczema(Atopic disease), or Hey fever?
If Yes, please circle it. (Asthma 喘息・Eczema(atopic disease)アトピー性疾患・Hey fever 花粉症)

＊Do you drink alcohol? アルコールは飲みますか？
If Yes, how often, what kind of and how much do you have? 頻度/種類/量

☐ Never ☐ Sometimes 時々(times/month) ☐ Often 頻繁に(times/week)
What kind of alcohol? 種類 ( )
How much do you drink at one time? 1度に飲む量 ( )

＊Do you smoke? 喫煙しますか？

☐ Never ☐Stopped smoking 禁煙した (Age:)
☐ Yes, I smoke.喫煙中 (Since age: , cigarettes/day)

＊Can you take or have you ever taken medicine as below? 以下の薬剤は飲めますか？/飲んだことがありますか？

☐ Powdered medicine粉薬 ☐ Capsulated medicineカプセル ☐ Pill form medicine錠剤 ☐ Lozengeトローチ

＊Questions for women:

☐ Pregnant 妊娠中 ☐ presently breastfeeding 授乳中 ☐ Irregular period 生理不順

＊How did you know this clinic? どのようにして当クリニックをお知りになりましたか？

KASHIWADE CLINIC
TEL. 0422-38-7277 FAX. 0422-38-7127