Medical　Questionnaire

Name	M・F	Date of Birth
		Cell Phone#
Address		

●What brings you here today？(今日はどうされましたか？)

□ fever(　　℃　) □ runny nose □ cough □ sore throat □ headache □ nausea □ chill

□weak feeling

□Other (　　)

How long have you experienced these symptoms? (症状はいつからですか？)

●Are you currently taking any medicine? (内服中のお薬はありますか？)

□Yes　What name of medicine? (お薬の名前)

□No

●Do you have any food or medicine allergies? (食べ物・お薬などのアレルギーはありますか？)

□Yes (Food・Medicine)　□No

What kind of allergies? (何のアレルギーですか？)

Since (　　) years old.　Symptoms?

● Have you had any diseases (including surgery) or diseases that you are currently treating?

(今までかかったことのある大きな病気（手術も含む）や、治療中の病気はありますか？)

●Do you drink alcohol? (飲酒はされていますか？)

□Yes　□No

How often do you drink? (どのくらいの頻度ですか？)

□2 or 3 times a week.　□More than 5 times a week.　□Other (　　)

●Do you smoke? (喫煙はされていますか？)

□Yes　□No

Since (　　) years old.　(　　) cigarettes a day.

Are you trying to stop smoking? (禁煙をご希望されますか？)

□Yes　□No

●Is there a possibility that you are pregnant？(妊娠の可能性はありますか？)

□Yes　□No

When was the first day and the last day of your menstruation period? (最終月経はいつからいつまででしたか？)

●Do you have any other concerns about your body or any other questions?

(その他気になることはありますか？)