よどやばし
メディカルクリニック

YODOYABASHI MEDICAL CLINIC

Patient ID :

Date : year month day

Medical Questionnaire for Internal Medicine（1）

Temp. _____℃

Name : _____

Sex : ☐ Male ☐ Female ☐ Other

D.O.B. : year month day Age : _____

Do you have health insurance? ☐ Yes ☐ No Nationality : _____

Address : _____

Tel : _____

1. Employment

☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Unemployed ☐ Student

2. What are your symptoms?

☐ Fever ☐ Sore throat ☐ Cough ☐ Phlegm ☐ Running nose
☐ Joint discomfort ☐ Headache ☐ Stomachache ☐ Nausea/Vomiting
☐ Diarrhea ☐ Constipation ☐ Loss of appetite ☐ Backache
☐ Shortness of breathe ☐ Lack of energy ☐ Dizziness ☐ Shivering
☐ High blood pressure ☐ Bloody stool ☐ Rash ☐ Cannot sleep
☐ Easily fatigued ☐ Numbness ☐ Swelling
☐ Other（ ）

3. When did the symptoms start?

Since approximately : year month day

4. What illnesses have you had in the past?

☐ Hypertension ☐ Diabetes ☐ Asthma ☐ Pneumonia ☐ Tuberculosis
☐ Kidney disease ☐ Liver disease ☐ Heart disease ☐ Arrhythmia ☐ Stroke
☐ Others（ ）

5. Are you currently undergoing any medical treatments?

☐ Yes（Disease : ）
☐ No

To the back

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6. Have you ever had any operations?

☐ Yes（Operation：　　）

☐ No

7. Are you currently taking any medications?

☐ Yes（Medicine：　　）

☐ No

8. Do you have any allergies?

☐ Yes（Allergy：　　）

☐ No

9. Do you smoke or drink alcohol?

Smoking：☐ Yes　☐ No　（About _____ cigarettes a day）

Drinking：☐ Yes　☐ No

10. Is there a possibility that you are pregnant?

☐ Yes　☐ No　☐ I don't know

11. How did you find our clinic?

☐ Live nearby ☐ Work nearby ☐ Homepage ☐ Advertisement ☐ Introduced by family

☐ Introduced by coworker ☐ Introduced by other hospitals ☐ Others（　　）

Thank you