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 Medical Oncology（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. Please describe your current health status

（ ）

3. What illnesses have you had in the past?

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

4. Please tick the box that best describes the situation

☐ Want to know everything that the physician knows
☐ Want to know the good parts, but not the bad parts
☐ Please tell everything to my family
☐ I don't know

5. How do you feel?

☐ Have pain ☐ Fell sluggish ☐ Nausea/Vomiting ☐ Constipation/Diarrhea
☐ Loss of appetite ☐ Swelling ☐ Shortness of breath ☐ Cough ☐ Itchiness
☐ Difficulty urinating ☐ Hiccups ☐ Difficulty sleeping ☐ Feel strong anxiety
☐ Depression ☐ Nothing particular

To the back

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Medical Questionnaire for Internal Medicine（2）

6. Do you have any worries besides your health issues?

☐ About my family ☐ About my work ☐ Financial issues

☐ Other（ ） ☐ Nothing particular

7. What do you expect from our clinic?

（ ）

8. Are you currently undergoing any medical treatments?

☐ Yes （Disease： ）

☐ No

9. Have you ever had any operations?

☐ Yes （Operation： ）

☐ No

10. Are you currently taking any medications?

☐ Yes （Medicine： ）

☐ No

11. Do you have any allergies?

☐ Yes （Allergy： ）

☐ No

12. Do you smoke or drink alcohol?

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

Drinking： ☐ Yes ☐ No

13. Is there a possibility that you are pregnant?

☐ Yes ☐ No ☐ I don't know

14. 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