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 Own Expense（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 kind of Injection/IV Drip/Internal Use are you thinking to have?

☐ Myer's Cocktail ☐ Vitamin Boost ☐ Glutathione ☐ Hangover Rescue
☐ Athletic Performance ☐ Hydration Boost ☐ Jet Lag Relief
☐ Energy Recharge ☐ Cold & Flu Therapy ☐ Anti-Aging ☐ Soothing Sleep
☐ Party Preparation ☐ Stress Relief ☐ Immune Boost ☐ Placenta Therapy
☐ Pre-martial Health Check-up ☐ STI Testing ☐ Male Infertility
☐ Laser Removal for certain projection ☐ Gynecology ☐ GIA Therapy
☐ Health Check-up ☐ Vaccination ☐ Pre/After-Travel ☐ Quit Smoking
☐ Other（ ）

3. What illnesses have you had in the past?

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

4. Are you currently undergoing any medical treatments?

☐ Yes （Disease : ）
☐ No

To the back

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5. Have you ever had any operations?

☐ Yes（Operation：　　）

☐ No

6. Are you currently taking any medications?

☐ Yes（Medicine：　　）

☐ No

7. Do you have any allergies?

☐ Yes（Allergy：　　）

☐ No

8. Do you smoke or drink alcohol?

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

Drinking：☐ Yes　☐ No

9. Is there a possibility that you are pregnant?

☐ Yes　☐ No　☐ I don’t know

10. 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