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 Palliative Care（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

よどやばし
メディカルクリニック
By your Side

YODOYABASHI MEDICAL CLINIC

Patient ID：

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. 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