

Medical Questionnaire for Urology (1)

Temp. _____℃

Name : _____

Sex : Male Female Other

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

Do you have health insurance? Yes No Nationality : _____

Address : _____

Tel : _____

We are going to take a urine test

1. Employment

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

2. What are your symptoms?

Difficulty of urination Hematuria Micturition pain
 Frequent urination Incomplete voiding Lower abdominal pain
 Urinary incontinence Genital abnormalities Infertility
 Nocturia 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

YODOYABASHI MEDICAL CLINIC

Medical Questionnaire for Urology (2)

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