Medical Questionnaire

Day Month Year

Date / /

Body temperature ℃

	First name / Last name	Sex	Nationality
Name			
Date of Birth	Day / Month / Year (Age)		
Address	Postal code		
Telephone number			

1. What are your current concerns? ・When did your symptom start？ ( ) ・Have you ever visited any other hospital for the symptom？ (Yes ・ No) ・If yes, please indicate the medical institution？ ( )	
2. Are you currently being treated for any medical conditions？	Yes ( ) No
3. Are you currently taking any medications?	Yes ( ) No
4. Have you had any serious illnesses or surgeries?	Yes ( ) No
5. Do you have allergies to any medications or foods?	Yes（medicine： food：) (other：) No
※ For Famale Are you currenty pregnant or breastfeeding?	No ・ pregnant ・ breastfeeding