ID（ ） ◆MedicalQuestionnaire◆ Saijyo central hospital

Name	（M・F）	Birthday	／ ／

Front **Back**

…**Today**（ / / ） **Reason for visit**

【From When?】

【What your symptom?】

temperature ℃ weight kg

※Please mark a relevant part.

①Please put a circle around the symptoms which you apply.

- ・temperature from when?（ ） highest …（ degrees)
- ・stomachache from when?（ ）
- ・vomiting from when?（ ）How often…about（ ）times
- ・diarrhea from when?（ ）How often…about（ ）times
- ・stools about （ ） a day

・headache ・sore throat ・cough ・sputum ・chest pain ・dizziness
・eczema ・appetite loss ・nausea ・others（ ）

②Have you ever been hospitalized and operation befor?

《When》 《Name of disease》

③Have you ever been consulted by a doctor next diseases?

・heart disease ・liver trouble ・kidney trouble ・diabetes ・allergy
・asthma ・high blood pressure ・others （ ）

④Are you taking anything medicines?

《Name of medicine》

⑤When you took a medicine or injected, did you feel bad, got hives or got asthma?

《Name of medicine》 《symptom》

⑥Are you being pregnancy now? （ Yes ・ No ）
Are you giving the breast to your baby? （ Yes ・ No ）

⑦Is it possible for you to become pregnant now? （ Yes ・ No ）

⑧Do you drink? （ Yes ・ No ）
↳kind How much a day

⑨Do you smoke cigarettes? （ Yes ・ No ）
↳How much a day