Medical Questionnaire

Date: 20 / /

Name: ______ Sex: Female / Male Date of Birth: M・T・S・H / / /

Address: ______

Telephone Number: ______

Temperature: ℃ Weight (under 10 years old only): kg

1. What are your symptoms?

EAR (right/left): painful / itchy / hard to hear / muffled hearing / want to clean ears / discharge / dizzy / tinnitus / want to consult about hearing aid

NOSE : discharge / stuffy / sneeze / postnasal drip / stinky discharge / nose bleed / painful inside / itchy inside / dry inside / doesn't smell at all /

THROAT : dry mouth / mouth ulcer / bad breath / doesn't taste at all / painful / something stuck in throat / hoarse voice / hard to talk / cough / phlegm

OTHERS : snore loud / apnea syndrome / facial paralysis / lump in face or neck
other symptoms______

2. How long have you been feeling this way?
since ______

3. Your medical history
heart disease / stroke / cerebral hemorrhage / hyperlipidaemia / liver disease / kidney disease / prostatic hypertrophy /
glaucoma / diabetic / asthma /atopic dermatitis
others______
none

4. Are you taking any other medicine now?
No / Yes ______

5. Are you allergic to anything?
No / Yes ______

6. Are you pregnant or breastfeed?
maybe pregnant / pregnant ⇒ due date: / /
breastfeed

7. Do you smoke? No / Yes ______ cigarettes a day

8. Is there anything to ask your doctor?
______

9. Would you like to take generic medicine? Yes / No

10. How did you know this clinic?
introduced by an acquaintance / advertisement on telegraph poles / neighborhood / web site / NTT book /
others______

Thank you very much.

(staff only: saturation %)