Medical Questionnaire: Orthopedics

ID: Date of Visit:

※Please hand in any referral letter or X-ray films/CD-ROMs from other hospitals.

Name Gender (M ・ F) Date of Birth yy - mm - dd

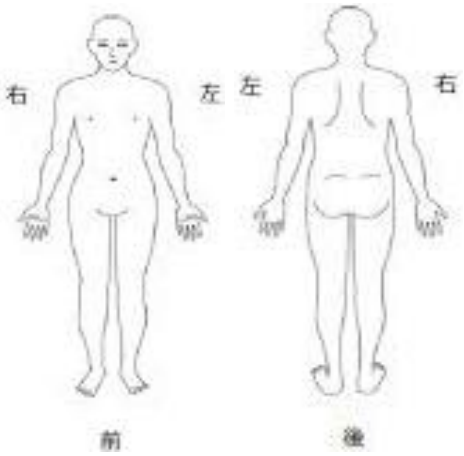
Zip code: TEL

Adress (Home) – –

(Cell) – –

◆Please describe your symptoms.

※Mark the place of the symptoms



◆When did the symptoms start?

◆How did this happen?

(injruy ・ accident ・ on job ・ sports ・ others)

Please descreibe :

◆Did you visit other hospital for the symptoms? (Yes ・No)

Name of the hospital :

◆Do you have any medical condition under treatment? (Yes ・ No)

※If yes, please check/fill in the corresponding form.

・high blood pressure ・heart disease ・diabetes ・asthma ・others

◆Are you currently taking any medications? (Yes ・ No)

Name of the medication:

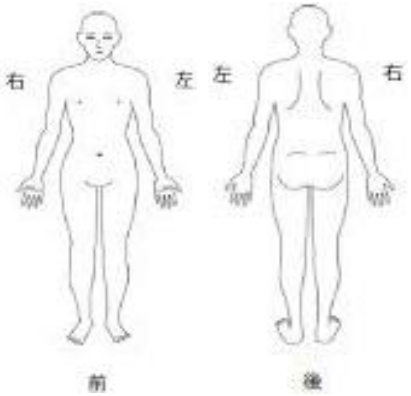
※Please hand in the prescription record if you have them.

◆Are you allergic to any foods or medications? (Yes ・ No)

Please describe:

◆Have you previously had any illness/ surgery/ injury?

※Please decribe below and mark the place of injury/ surgery:



◆Do you wish X-ray exam? (Yes ・ No)

◆Is ther a possibility that you are pregnant? (Yes ・ No)

※If yes (Pregnancy week: weeks)

◆Do you have certification of Long-Term Care Insurance? (Yes ・ No)

◆Do you wish to join rehabilitation program at our hospital? (Yes ・ No)

※Rehabilitation program is ordered under doctor's diagnosis.