Medical Questionnaire: Primary Care / Pulmonology / Neurology

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:

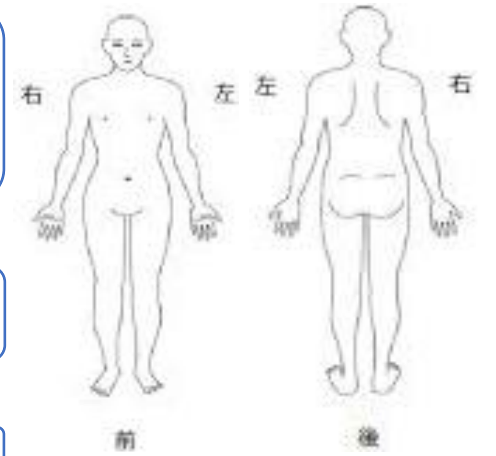
Adress

TEL
(Home) – –
(Cell) – –

◆Please describe your symptoms.

[ ]

※Mark the place of the symptoms



◆When did the symptoms start?

[ ]

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

[Name of the hospital：]

◆Have you previously had any medical conditions? (Yes ・ No) If so, please describe.

[Name of ilness:]

◆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:]

◆Do you smoke? (Yes ・ No) [amount： packs/day, duration： years]

◆Do you drink alcohol? (Yes ・ No) [amount： ml/day, frequency： days/week]

◆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.