Medical Questionnaire

Date of Visit:

Full Name: Gender: M / F Date of Birth:

Address: Phone Number:

●Which department do you wish to visit today?

☐General Medicine ☐Pulmonary Medicine ☐Neurology

●Please describe your symptoms.

【Do you have a referral letter from another hospital? ☐Yes ☐No】

●When did the symptoms start?

●Do you have previous medical conditions? If so, please describe.

☐No ☐Yes（ ）

●Do you have any medical condition under treatment? If so, please describe.

☐No ☐Yes（ ）

●Are you currently taking any medication?

☐No ☐Yes（☐I brought prescription record today. ☐I did not bring the prescription record.）

●Do you have any allergy?

☐No ☐Yes（☐Medication： ☐Food: ）

●Do you smoke? ☐No ☐Yes（amount: packs/day, duration: years）

Do you drink alcohol? ☐No ☐Yes（amount: frequency: days/week）

●Are you currently pregnant? Is there a possibility that you might be pregnant?

☐No ☐Yes（☐Gestational week: ☐Have not visited women's clinic yet）

●Do you have certification for Long-Term Care Insurance?

☐No ☐Yes

(Certified level：☐Requiring long-term care【 】, ☐Requiring support【 】, ☐forgot the numbers）