# Medical Questionnaire

Date . .

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|---|---|---|
| フリガナ | | Date of Birth . . . |
| Name | | Male ・ Female |
| Address | 〒 − | |
| ☎Home phone ( ) | | ☎Mobile phone ( ) |

【Your Job】 standing work･office work･heavy lifting･driver･housewife･unemployed
other（ ）

【Regularly practiced sports】 no ・ yes（ ）

★ Have you had a medical check up within a year? no ・ yes

★ I'm pregnant no ・ yes（ weeks ）･do not know

| |
|---|
| **Please state your symptoms simply.** |
| **Onset of your symptoms.** |
| **Cause of your symptoms(if any).**<br>fall ・ hit ・ twisted ・ cut ・ not sure ・ other（ ） |
| **Your symptoms caused by a…**<br>**Industrial Accident or During commuting?** no ・ yes<br>**Traffic Accident?** no･ yes（ perpetrator ・ victim ・ single accident ）<br>※If yes･･･ You are( car ・ bike ・ bicycle Pedestrian )<br>The other party（ car ・ bike ・ bicycle Pedestrian ） |
| **Have you ever been treated before regarding the above symptoms?**<br>no･ yes(When ）(Where ） |
| **Preceding illnesses** no ・ yes<br>hypertension ・ hyperglycemia ・ diabetes ・ bronchial asthma ・ dialysis<br>other( )( Where ） |
| **History of surgery?** no ・ yes<br>(What kind )<br>(Where ) |
| **Have you ever experienced any side effects from any medication?**<br>no ・ yes(Name of Medication: ） |
| **How did you know about this clinic?**<br>internet ・ sign board ・ advertisement ・ introduction(family ・ friend ・ hospital )<br>other( ） |
| **May we send direct mail to you?** no ・ yes |
| **Do you have a medical record handbook?** yes(at home/with me) ・ no |
| **Do you have a letter of reference?** no ・ yes |
| **Do you want to register your "My-numberCard? If so, would you agree to the doctor views your medical record by My-number card?** no ・ yes |

Our clinic strive to offer high quality medical care by obtain medical information from "My-number Card".

Please consider registering "My-number Card" for obtaining accurate medical information.

◆Addition for obtaining medical information…1point