Medical Questionnaire

Date . .

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). fall ・ hit ・ twisted ・ cut ・ not sure ・ other（ ）
Your symptoms caused by a… **Industrial Accident or During commuting?** no ・ yes **Traffic Accident?** no･ yes（ perpetrator ・ victim ・ single accident ） ※If yes･･･ You are(car ・ bike ・ bicycle Pedestrian) The other party（ car ・ bike ・ bicycle Pedestrian ）
Have you ever been treated before regarding the above symptoms? no･ yes(When ）(Where ）
Preceding illnesses no ・ yes hypertension ・ hyperglycemia ・ diabetes ・ bronchial asthma ・ dialysis other( )(Where ）
History of surgery? no ・ yes (What kind) (Where)
Have you ever experienced any side effects from any medication? no ・ yes(Name of Medication: ）
How did you know about this clinic? internet ・ sign board ・ advertisement ・ introduction(family ・ friend ・ hospital) 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