

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...9point