

Questionnaire

Date of entry

年 月 日

Name		Male	Date of birth	year	month	day	Age
		female		/	/		
address	〒						
Phone Number	-		-		Mobile	home	other ()
	We may contact you. Please fill in the phone number that can be contacted.						
Height	cm	Weight	kg	Today's body temperature		°C	

Please answer the following questions about your physical condition as a reference for your medical treatment.

1. Check the symptoms that apply to you and fill in when you started.

<input type="checkbox"/> fever	From	month	day	The highest body temperature	°C
<input type="checkbox"/> cough <input type="checkbox"/> runny nose <input type="checkbox"/> sore throat		month	day		
<input type="checkbox"/> headache		month	day		
<input type="checkbox"/> decreased appetite		month	day		
<input type="checkbox"/> nausea <input type="checkbox"/> vomiting		month	day		
<input type="checkbox"/> abdominal pain (<input type="checkbox"/> upper <input type="checkbox"/> lower)		month	day		
<input type="checkbox"/> diarrhea		month	day		
<input type="checkbox"/> dizziness		month	day		
<input type="checkbox"/> fatigue		month	day		
<input type="checkbox"/> chest pain <input type="checkbox"/> palpitations		month	day		
<input type="checkbox"/> shortness of		month	day		
<input type="checkbox"/> Other (month	day		

2. Do you have any allergies to medications? No Yes (Drug Name)

3. Do you have any food allergies? No Yes ()

4. Do you have hay fever? No Yes ()

5. Do you have any previous illnesses or ongoing treatment? No Yes
 Hypertension Diabetes Mellitus Dyslipidemia Asthma Others ()

6. Are there any medications you are currently taking? None available (Drug Name:)

7. Do any family members (blood relatives) have the following diseases? No Yes
 Hypertension Diabetes Mellitus Bronchial Asthma Heart Disease Cerebral Infarction
 Cerebral Hemorrhage Cancer

8. Have you ever had surgery? No Yes (disease name/)
(When/)

9. Drinking Don't drink Drink → every day sometimes () times a month

10. Smoking Don't smoke Smoke Smoked in the past
(Smoking per day cigarette) (How many years)

Questions for women

11. Are you currently pregnant? Yes (Expected date of delivery / Months of pregnancy)
 No I don't know

12. Are you currently breastfeeding? No Yes

The personal information you fill in will be used only for medical treatment. Thank you for your cooperation.