(医) 太融寺町谷口医院　問診票

Taiyuji-cho Taniguchi Clinic Medical Questionnaire

ID

(year) (month) (day)

		Where are you from?(What is your nationality?)
Name		
Date of birth	(　　) year (　　) month (　　) day	(　　　　)
Gender	☐ Male　☐ Female　☐ (　　)	
Address	〒	
Phone	Mobile phone	E-mail address

● What is wrong with you? (You may talk to a doctor personally)

(　　　　)

●Please write down any current illnesses and also past history of illness.

☐hypertention　☐hyper lipidaemia(hyper tirgly ceridemia, hypercholesterolemia)　☐diabetes

☐hyperuricemia　☐tuberculosis(TB)　☐hepatitis B　☐hepatitis C　☐syphilis

☐HIV infection　☐headache　☐insomnia　☐melancholy　☐anxiety neurosis

☐bronchial asthma　☐allergic rhinitis　☐allergic conjunctivitis　☐atopic dermatitis

☐nettle rash　☐foods allergy (causing foods :　　　　)

☐a drug rash (causing agent :　　　　)

☐chronic gastritis　☐a stomach ulcer　☐a duodenal ulcer　☐irritable bowel synarome(IBS)

☐hyperthyroidism　☐cancer　☐epilepsy

☐the others (　　　　)

●Have you ever been allergic to medications or foods?

Yes (name of a medication :　　　　symptoms:　　　　)

No

●Are you taking any medication now?

No ・ Yes → Please provide your current medication correctly.Some combinations of particular drugs may cause interactions and may also affect your examination.Therefore, in some cases the clinic will not prescribe medication.

(ex: an internal medicine・inhalant・nose drops・eye drops・external medicine・health foods・supplement)

(　　　　)

●Question for women

Are you(May you be)pregnant? (You may talk to a doctor personally.)

☐Yes → (　　)months

☐ No → When is your last menstrual period?

Since (　　　　)　For (　　)days