Consultation Application Form			Patient No. Date:
Name			M ・ F
Date of Birth			Age:
Address			
Home Tel No.		Mobile No.	

Medical Questionnaire

1. What seems to be a problem or the purpose of your visit today?

   _____

   _____

   Since when have you been experiencing this problem? _____

   If your symptoms have been accompanied by a fever, please mention the highest fever you've had and when. _____℃ *on* _____

1. Do you consent to us obtaining your Medical Information through your My Number Identification Card?

☐ I agree ☐ I disagree ☐ I don't have one

2. **Do you have a referral letter?** YES / NO

   Do you have any image-based data such as a CD or X-ray? YES / NO

3. **Are you currently receiving treatment for a disease or a problem?** YES / NO

   If YES, please give some details:

   _____ Treatment at _____ Hospital

4. **Are you currently taking any prescription medicine?** YES / NO

   Medicine Name_____

   Dosage _____ Time Period_____

5. **Have you undergone a health checkup within the last year (Yearly Health Checkup**

   OR Elderly Person's Health Checkup)? YES / NO

   Date of Checkup: _____

   Points of Concern:

   _____

   _____

6. **Have you had any major surgery or suffered from a serious disease?** YES / NO

   Age: _____ Surgery/Disease _____

   Age: _____ Surgery/Disease _____

7. **Are you allergic to any foods, medicine or metals?** YES / NO

   Allergic to _____ Reaction _____

8. **Are you prone to a rash from the use of compresses or tape?** YES / NO

9. **Do you drink alcohol?** YES / NO

10. **Do you smoke?** YES / NO

    _____ cigarettes/day Been Smoking for _____ years

11. **Do you have a sensitive stomach?** YES / NO

Only for Women

12. **Are you currently pregnant or possibly pregnant?** YES / NO

13. **Are you currently breastfeeding?** YES / NO