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

Mobile No. (- -) Car No. _____ Car Type/Color _____

Name _____ Temperature _____℃

ID _____

Fever Outpatients Medical Questionnaire

1. Have you had a fever of over 37.5℃ since yesterday until now? [YES / NO]
2. When did you first start showing symptoms? [Date: Time:]
3. Have you been infected by Covid until now? [YES / NO]

   If YES, please mention when _____
4. Have you been vaccinated against Covid? [YES / NO]

   If YES, please mention when was your last vaccination

   Date: _____ Dosage No. _____
5. Have you been overseas any time during the last 2 weeks? [YES / NO]

   If YES, Do you have any skin rash or bumps? [YES / NO]
6. Are you living with anyone who has been infected by Covid or the flu? [YES / NO]
7. Did you show a positive result to a Covid or Flu antigen test at home prior to coming to the hospital? [YES / NO]

   If YES, was it [Flu positive / Covid positive]

8. Would you like to take an antigen (Covid + Influenza) test OR a Covid PCR test?

   [YES / NO]

9. What is your profession? [ ]

10. Please ○ your current symptoms?

    ・High fever of above 37.5℃ in the last 24 hours ・Cough ・Phlegm

    ・Breathing Difficulty ・Throat pain ・Lethargy ・Headache ・Nausea

    ・Diarrhea ・Red Eyes ・Lack of Smell/Taste Sense ・Joint pain

    ・Muscle pain ・Loss of Appetite

11. If you have any of the following prevalent conditions, please ○ them

    ・Cancer ・Chronic Respiratory Disease ・Chronic Kidney Disease

    ・Cardiovascular Disease ・Cerebrovascular Disease ・Smoking history

    ・High-blood Pressure ・Diabetes ・Dyslipidemia ・Obesity

    ・Pregnant ・Organ Transplant ・Under Anticancer drug use

    ・Low Immunity due to the use of Immunosuppressant drugs