Medical Questionnaire

Please answer the following questions. The information provided will not be used except for the purpose of your medical treatment.

Name : _____
(Family) (Given)

Company Name : _____

Address : _____

Tel : _____

Home Address : _____

Tel : _____

1. Have you previously had any serious illnesses, injuries, operations, hospitalizations?
Date, details ( )
Date, details ( )
Have you ever had a blood transfusion? Yes / No

2. Are you currently undergoing treatment for any diseases?

3. Are you currently taking any medicines? Please give name and dosage.

4. Are you allergic to any medicines? ex: come out in a rash, etc.

5. Does anyone in your family have one of the following illnesses?
Cerebrovascular accident / Heart disease / Cardiac infarction / Hypertension
Liver disease / Cancer (sarcoma) / Diabetes / Other ( )

6. Do you smoke?
No
Yes (current amount ___ cigarettes/day, duration ___ years)
No, but I used to (previous amount ___ cigarettes/day, duration ___ years)

7. Do you drink alcohol?
Everyday / Sometimes / No

8. Is there anything else you would like to add?

Hatchobori Clinic