浦安せきぐちクリニック　Urayasu Sekiguchi Clinic

INTERNAL MEDICINE

year　　month　　day

Name:	☐ Male ☐ Female	Date of birth:(mm/dd/yy)
Address:		Age:
Tel:		
Phone Number:		Whom may I contact in case of on emergency!!

Please answer the following questions

1. What are your symptoms and how long have you had these problems?

2. Have you had any serious illness, injury or operation in the past?

3. Does anyone in your family have the following illness?

☐ Hypertension　☐ Diabetes Mellitus　☐ Stroke　☐ Heart Attack

☐ Mental Disease　☐ Bronchial Asthma　☐ Cancer　☐ Collagen Vascular disease

4. Are you currently under any prescription/ nonprescription medical treatment?

5. Are you allergic to any medicine or pollen? State name if you know.

6. Beverage consumption

Alcohol (Amount　　)　　Smoking (　　)

Coffee (　　)　　Others　(　　)

7. Menstrual period

(a) Date of last period

(b) Regular or irregular

8. Sleep

Approximate time and duration of sleep

9. Bowel habits

☐ Regular　☐ Constipated　☐ Loose

10. Would you like to mention something else?