Tanaka Clinic - General Medicine Questionnaire

ID: Date (YYYY/MM/DD): / /

※If you have a medication record, referral letter, X-ray, or image CD, please hand it to the receptionist.

Name: Sex assigned at birth: (M / F) Date of Birth (YYYY/MM/DD): / /

Postal Code:

Address:

Phone Number

(Home) – –

(Mobile) – –

◆ What symptoms brought you to the clinic today?

Please describe:

◆ When did these symptoms start?

◆ Have you had any other illnesses in the past? (Yes / No)

If yes, please specify:

◆ Are you currently receiving treatment for any illness? (Yes / No)

◆ Are you currently taking any medications? (Yes / No)

If yes, please list the names:

◆ Do you have any allergies? (Yes / No)

If yes, please specify (e.g., medications, foods):

◆ Smoking history: (None / Yes)

Amount per day:【 】cigarettes × 【 】years

◆ Alcohol consumption: (None / Yes)

Type of alcohol:【 】× Amount per day:【 】× 【 】times per week

◆ Please list any known illnesses in your family:

◆ For Female Patients: Are you currently pregnant or possibly pregnant? (Yes / No)

If yes: (Pregnancy Week ___ / Not yet tested)

◆ Do you have long-term care insurance certification? (Yes / No)

Certification level: Care level:【 1 2 】Support level【 1 2 3 4 5 】 【Unknown】