

General Medical Inquiry Form 医科問診票

Year Month Day
20__年__月__日

It is very important to know your medical history and state of health. All information given here is strictly confidential.
あなたの既往症と体調を事前に把握しておく事は大切な事です。個人情報の秘匿は守られます。

General Patient Information 患者の情報

フリガナ:
Last name 姓 First name(s) 名 _____

Male 男 Female 女 Occupation 職業 _____ Nationality 国籍 _____

Date of Birth 生年月日 Year: Month: Day: Address _____
in Japan
日本語での住所

Language(s) 言語 _____

Phone number 電話 _____

E-mail/fax メール・ファックス _____

Chief Complaint(s) 主訴

<input type="radio"/> Fever, high temperature 熱 _____ °C	<input type="radio"/> Itching かゆみ	<input type="radio"/> High blood pressure 高血圧	<input type="radio"/> Weight loss/gain 体重減少・増加
<input type="radio"/> Chills 寒気	<input type="radio"/> Nausea 吐き気	<input type="radio"/> Chest pain 胸痛	<input type="radio"/> Pain in... 痛み _____
<input type="radio"/> Headache 頭痛	<input type="radio"/> Vomiting 嘔吐	<input type="radio"/> Shortness of breath 息切れ	<input type="radio"/> Burns やけど
<input type="radio"/> Sore throat 咽頭痛	<input type="radio"/> Stomachache 腹痛	<input type="radio"/> Palpitations 動悸	<input type="radio"/> Injury 外傷
<input type="radio"/> Runny nose 鼻水	<input type="radio"/> Diarrhea 下痢	<input type="radio"/> Dizziness めまい	<input type="radio"/> Sprain 捻挫
<input type="radio"/> Cough 咳	<input type="radio"/> Blood in stool 血便	<input type="radio"/> Ringing in ears 耳鳴り	<input type="radio"/> Lump しこり
<input type="radio"/> Rash 発疹	<input type="radio"/> Blood in urine 血尿	<input type="radio"/> Numbness しびれ	<input type="radio"/> Tumor 腫瘍
	<input type="radio"/> Discomfort urinating 排尿痛	<input type="radio"/> Swelling むくみ	<input type="radio"/> Hemorrhoid 痔
<input type="radio"/> Other (please write) 他 _____	<input type="radio"/> Fatigue 疲れやすい		

How long have you had this? どのくらい? _____ hour(s) 時間 day(s) 日間 week(s) 週間 month(s) ヶ月 _____ year(s) 年間

Illness and Surgical History 既往歴、手術歴

Please select any illnesses you have had. 該当する疾患に印をつけて下さい

<input type="radio"/> High blood pressure 高血圧	<input type="radio"/> Kidney disease 腎臓病	<input type="radio"/> Convulsions or Epilepsy けいれん・てんかん
<input type="radio"/> Diabetes 糖尿病	<input type="radio"/> Liver disease 肝臓病	<input type="radio"/> Tuberculosis 結核
<input type="radio"/> Heart disease 心疾患	<input type="radio"/> Thyroid problems 甲状腺異常	<input type="radio"/> Hepatitis B or C B/C型肝炎
<input type="radio"/> Cerebrovascular disease 脳血管疾患	<input type="radio"/> Asthma 喘息	<input type="radio"/> HIV エイズ
<input type="radio"/> Other (please write) 他 _____		

Have you had any operations before? 手術歴

No Yes What? 何の手術 _____

Have you had a blood transfusion? 輸血歴

No Yes What was it for? 何の為 _____

Do you tend to bleed much? 出血傾向 No Yes Not sure わからない

Family History 家族歴

Please select any illnesses your immediate family have had. 親族での

<input type="radio"/> High blood pressure 高血圧	<input type="radio"/> Kidney disease 腎臓病	<input type="radio"/> Cancer 癌
<input type="radio"/> Diabetes 糖尿病	<input type="radio"/> Liver disease 肝臓病	<input type="radio"/> Hereditary diseases 遺伝子関連疾患
<input type="radio"/> Other (please write) 他 _____		

Go to REVERSE SIDE

Allergies アレルギー

Have you ever been allergic to anything? (medicine, food, other) アレルギーの有無(薬、食べ物、他)

No Yes What? 何に

Have you had side effects caused by medicine? 薬の副作用の有無

No Yes Which medicine? 薬名

Have you had problems after having a local or general anesthetic? 全身又は局所麻酔歴

No Yes What? 何に

Questions for Women 女性への質問

Are you pregnant? 妊娠していますか

No Yes Not sure わからない

Are you currently breastfeeding? 今、授乳中ですか

No Yes

Are you taking contraceptive pills? 今、避妊用のピルを服用していますか

No Yes

Medication 薬

Are you currently taking any prescribed or over-the-counter medicine(s)? 今、処方薬又は売薬を服用していますか

No Yes Which medicine(s)? 何の薬を

Bufferin Aspirin Warfarin ('Coumadin,' 'Warfilone,' 'Marevan')

Other: Please write the medicine name(s). 薬名を具体的に書いて下さい

Why are you taking it/ them? 何の為

Alcohol and Tobacco お酒とタバコ

Do you regularly drink alcohol? お酒を定期的に飲みますか

No Yes How much in 1 week? 週にどのくらい? →

1 beer (500ml)



ビール500ml

1 glass of wine



グラスワイン

1 measure of spirits



リキュール

Other: その他

Do you smoke? タバコは吸いますか

No Yes How many a day? 一日に ___ 本 How long have you smoked? どのくらい ___ months ケ月間 ___ years 年間

Did you smoke before? 以前に吸ったことありますか

No Yes How many a day? 一日に ___ 本 When did you stop? いつやめましたか ___ months ago ケ月前 ___ years ago 年前

Treatment Preferences and Medical Fees 治療の希望と医療費

Do you have Japanese Health Insurance or private medical insurance? 日本の保険証又は他の私的医療保険証をお持ちですか

No Yes

Do you only want treatment for your main problem? 現在困っている問題の治療のみ希望しますか

No Yes Not sure わからない

Please return this form. Thank you.