Ophthalmology Inquiry Form 眼科問診票

Year 20 年 Month ____ 月 Day ____ 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 日本での住所

Language(s) 言語

Phone number 電話・

E-mail/fax メール・ファックス

Eye Test 視力の検査

Do you wish to have an eye test? 視力の検査の受診希望
No◯ Yes◯

Chief Complaint(s) 主訴□□□*If none, go to next section*

◯ Pain in eye(s) 目が痛い
◯ Eye injury 目の外傷
◯ Bloodshot eye(s) 目の充血
◯ Watery eye(s) なみだ目
◯ Discharge from eye(s) 目やに
◯ Foreign body in eye(s) 目の異物
◯ Blurred vision かすみ目
◯ Double vision 複視
◯ Sensitivity to bright light まぶしい
◯ Tired eyes 疲れ目
◯ Headache 頭痛

◯ Other (please write) 他

Which eye? どちらの目 Left eye◯左の目 Right eye◯右の目

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

Please write any other general eye problems you have. 他に気になることを書いて下さい

Eyesight Correction 視力矯正

How is your eyesight? 視力は？ Near(short)sighted◯近視 Far(long)sighted◯遠視 Good vision◯良好

Do you wear glasses? メガネをかけていますか No◯ Yes◯

Do you wear contact lenses? コンタクトレンズをしていますか No◯ Yes◯

Have you had vision-correcting eye surgery? 視力矯正手術 No◯ Yes◯

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

◯ High blood pressure 高血圧
◯ Diabetes 糖尿病
◯ Heart disease 心疾患
◯ Cerebrovascular disease 脳血管疾患
◯ Kidney disease 腎臓病
◯ Liver disease 肝臓病
◯ Thyroid problems 甲状腺異常
◯ Asthma 喘息
◯ Convulsions or Epilepsy けいれん・てんかん
◯ Tuberculosis 結核
◯ Hepatitis B or C B/C型肝炎
◯ HIV エイズ

◯ Other (please write) 他

Have you had any operations before? 手術暦
No◯ Yes◯→ What? 何の手術

Have you had a blood transfusion? 輸血暦
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

Go to REVERSE SIDE

Family History 家族歴

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

◯ High blood pressure 高血圧　◯ Kidney disease 腎臓病　◯ Cancer 癌
◯ Diabetes 糖尿病　◯ Liver disease 肝臓病　◯ Hereditary diseases 遺伝子関連疾患

◯ Other (please write) 他

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)	1 glass of wine	1 measure of spirits	Other: その他
 ×___	 ×___	 ×___	
ビール500ml	グラスワイン	リキュール	

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 ヶ月間___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 ヶ月前___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.