MIH CLINIC YOYOGI

Medical Questionnaire

Date:

Name		Date of Birth
Parent's Name (At pediatrics)		TEL :
Address	〒	E-mail :
Body temperature	℃	Weight : kg

■ How many times is our clinic? First visit (please below answer) / Return visit

■ Internal Medicine(内科) Pediatrics(小児科) Allergy Department(アレルギー科)
Dermatology(皮膚科) Psychosomatic Medicine(心療内科)

■ What brings you here?

_____

_____

■ How long you have experienced these symptoms?

_____

■ Did you go to another hospital?

YES / NO 〔The Name of the Hospital : _____〕

■Have you ever been seriously ill, injured, hospitalized, or currently undergoing treatment?

YES / NO

〔What kind of illness/injury was it? : _____〕

When (about month ago / about year ago)

Currently under treatment: (Name of medical institution: _____)

■What medication dose you currently?

YES / NO

(your dose medications name :)

☆★☆Please fill out back the sheet☆★☆

■Have you ever been told that you have an allergy or peculiar constitution?

YES / NO

(medications name :

food name : others:)

■Cigarettes: Do not smoke, used to smoke in the past, still smoke

quantity／day (～ age)

■alcole : Do not drink or drink :

daily・2～3 quantity/week・2～3 quantity/month・2～3 quantity/year

■Possibility of pregnant women : YES / NO Are you breastfeed？: YES / NO

Medical Questionnaire for Outpatients with Fever

(Please check the another medical questionnaire sheet)

Date: / / /

>Have you ever been contact a parson of corona virus positive? Yes/No

If you, 'yes', please fill out blank box in the details.

If you have some idea, please fill in the details.

If you were told by the public health center that you were a close contact, please enter that information as well.

If you have not had any contact with a positive person, please write "None".

> Do you have any of the following diseases or preferences? If yes, please select one.

If not, please select "Not applicable".

- Malignant tumor
- Chronic obstructive pulmonary disease
- Chronic kidney disease
- Hypertension
- Diabetes mellitus
- Dyslipidemia
- Obesity (BMI over 30)
- Smoking history
- Not applicable

>Have you ever been taken the corona vaccine? Yes/No

- 1st taken : / /
- 2nd taken: / / / Not vaccinated

Type of vaccine (name of manufacturer):

Vaccine type (manufacturer): Pfizer / Moderna / Other " " / Unknown

- Not vaccinated