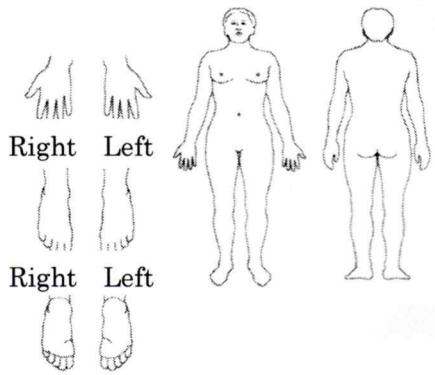
体温：　　患者 No.＿＿＿＿＿＿＿＿＿＿　　年　　月　　日

☆Please fill out this medical history form.

NAME		Gender	M / F
Address	〒　　－		
Phone number			
Birthday	/year　　/month　　/day	Age	(　　)Years old
Occupation			

【1】What is your symptom or chief complaint?

(　　)



【2】Please check☑ the illness you've hit.

- ☐ Duodenal ulcer/Gastric ulcer
- ☐ Gastritis
- ☐ Colonic polyp
- ☐ Prostatic hypertrophy
- ☐ Glaucoma
- ☐ Gallstone
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Angina pectoris
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Autonomic imbalance
- ☐ Asthma
- ☐ Others (　　)

● Have you had surgery before?

☐ NO　☐ YES (When was the surgery? ＿＿＿＿＿＿ Type of surgery＿＿＿＿＿＿＿＿)

【3】Are you taking any medication right now?

☐ NO　☐ YES (Name of medicine　　)

【4】Do you have any allergies especially for medicine?

☐ NO　☐ YES (Name of medicine　　)

≪Question for women≫ present...

Pregnant?　NO ・ YES (Expected date of birth ＿＿＿＿＿＿)

Breastfeeding?　NO ・ YES

★Please issue insurance card.