Yr,Mon,Dy_____ # OUTPATIENT FORM v.13 No._____

Name:_____:____Male____Female____other

Birthdate: **Y**ear /**M**onth/ **D**ay_____

Address:〒_____

_____tel_____(_____)_____

Note; please complete this form as possible as you can. Every information requested in this form is very precious to provide you with accurate diagnosis and appropriate treatment, although you may not have answers to all the questions. Thank you very much for taking your valuable time.

1. Have you ever been taking any medicine for hypertension/diabetes/seizure disorder/other any disease?
   (No / Yes: Any medicine?_____
   _____)
2. Are you being treated for any of the following illnesses: Hypertension/ Diabetes Mellitus/
   a Heart/Kidney/ Liver/Brain/Nerve/ Hematological disease/ Epilepsy/Other?
   Please write down your illnesses
3. Do you have Glaucoma, or prostate-gland hypertrophy? (No / Yes:Any disease_____)
4. Have you ever had any operation or admission for any disease?
   When_____
   Name of illness_____
   When_____
   Name of illness_____
   When_____
   Name of illness_____
5. Does anybody in your family have Asthma, Atopic Dermatitis, or Allergic Rhinitis?
   (No / Yes: Who_____Any disease_____)
6. Does anybody in your family have a history of any disease as follows?
   Heart attack:_____Hypertension:_____
   Stroke:_____Diabetes:_____Lung disease:_____
   Liver disease/Hepatitis:_____Stomach ulcer:_____
   Kidney disease:_____Rheumatic disease:_____
   Cancer:_____Tuberculosis:_____Other:_____
7. Do you drink alcohol? (No / Yes: How much per day?_____)
8. Do you smoke? (No / Yes)
9. Are you pregnant now? (No / Yes)
10. Are you allergic to any medication or any food?
    (No / Yes:_____)

Note: When using Japanese health insurance, there may be severe restrictions on the types of medications that can be used and the duration of medication.