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

Name of Child:_____:____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. Your child goes to_____(Nursery, Kindergarten)
   _____(School)
2. Father's occupation:_____
3. Mother's occupation:_____
4. Number of your children:_____;he/she is_____th
5. Irregularities of pregnancy:(Normal / Abnormal: How_____
   _____)
6. Delivery: (Normal / Abnormal: How_____
   _____)
7. Weight at Birth:_____g
8. Irregularities at Birth: (Normal / Abnormal: How_____
   _____)
9. Feeding: (Breastfeeding / Formula / Mixed)
10. Has your child ever been taking any medicine for any disease?
    (No / Yes: Any medicine?_____
    _____)
11. Has your child ever had any operation or admission for any disease?
    When_____Where_____
    For Which Disease_____
    When_____Where_____
    For Which Disease_____
    When_____Where_____
    For Which Disease_____
12. Does your child have a history of a seizure disorder?
    (No / Yes: When_____since_____years old_____times)
13. Does anybody in his/her family have Asthma, Atopic Dermatitis, or Allergic Rhinitis?
    (No / Yes: Who_____Any disease_____)
14. Present Weight of your child:_____kg
15. Allergic to any medicine or any food? (No / Yes: Milk/ Egg/_____
    _____)

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.