

Yr, Mon, Dy \_\_\_\_\_ **OUTPATIENT FORM** v.14 No. \_\_\_\_\_

Name: \_\_\_\_\_ : \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ other \_\_\_\_\_

Birthdate: Year /Month/ Day \_\_\_\_\_

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.**

By submitting this questionnaire, you are deemed to have agreed to a medical contract under which you will be inspected, auscultated, and palpated without notice to any part of your body that is necessary for your medical diagnosis.