ID ____________

Health question

Date ____________

■ name

surname

given name

■ birthday (Year/Mouth/Date)

／　　／

■ Age　　　　(Male − Female)

■ adress

■ phone

■ occupation

■ height　　　cm

■ Nationality

■ weight　　　kg

■ E−mail

・What doctor do you want to see today ?

[Internal Medicine , Dermatology , Allergoimmunology , others]

・What are your symtoms ?

・When did they start ?

・Are there any medications that you take now ? Any medications ,please list.

・Have you had any operations ?

(Yes , No)

・Do you have any allergies to medications or food ? Please list.

・Life Style

Tobacco, cigaret(＋ or −)

Alcohol(＋ or −)

Diet(＋ or −)

Exercise(＋ or −)

・Would you mind asking you favorite food ＆ sport ?

Juban Clinic