NEW-TOKYO CLINIC
NEW-TOKYO HEART CLINIC

Questionnaire

Date
______year ______month ______day

ID: ____________ - ________

Name ______________________________

Sex
M ・ F

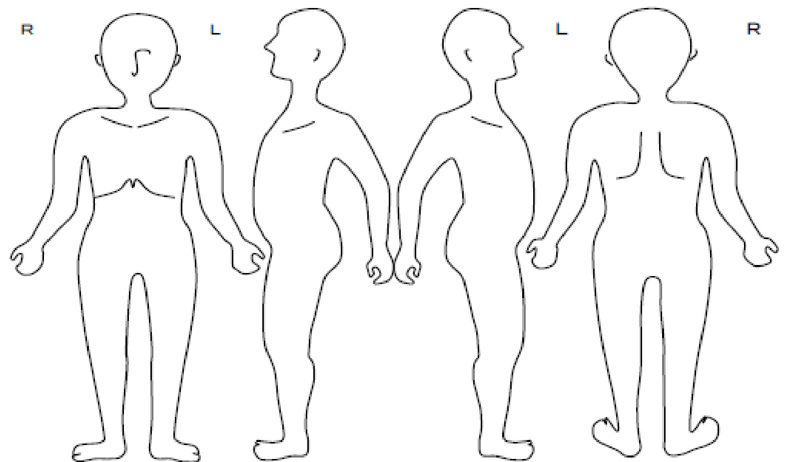
Date of birth
______year ______month ______day

Address ______________________________

Telephone
<Home>
<Mobile>

■ **Which part of your body seems to be the problem?**

・ Please mark the part of the body where you have a problem



・ How long have you had your symptoms?

____

・ What are your symptoms?

____

■ **Have you had any of the following? (Please indicate below the disease you had)**

☐ hypertension ☐ dyslipidemia ☐ diabetes
☐ liver disease ☐ bronchial asthma ☐ kidney trouble
☐ heart disease ☐ cerebro vascular disease ☐ cancer
☐ tuberculosis ☐ pneumonia
☐ others ( )

■ **Have you ever been allergic to medication or type of injection?** ☐ No ☐ Yes

Name of drug ( ) Type of injection ( )
Symptoms ( )

■ **Are you pregnant?** ☐ No ☐ Yes

Reception

新患	紹介	登録時間	医事担当	看護師	scan

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