General Patient Medical Inquiry Form 医科問診

Chief Complaint(s) 主訴

☐Fever 熱 _____C ☐Itching かゆみ ☐High blood pressure 高血圧 ☐Weight loss

☐Nausea 吐き気 ☐Chest pain 胸痛 ☐Weight gain

☐Chills 寒気 ☐Vomiting 嘔吐 ☐Palpitations 動悸 ☐Pain in 痛み _____

☐Headache 頭痛 ☐Stomachache 腹痛 ☐Shortness of breath 息切れ

☐Sore throat 咽頭痛 ☐Diarrhea 下痢 ☐Dizziness めまい ☐Burns 熱傷

☐Runny nose 鼻水 ☐Blood in stool 血便 ☐Ringing in ears 耳鳴り ☐Injury 外傷

☐Cough 咳 ☐Blood in urine 血尿 ☐Numbness しびれ ☐Sprain 捻挫

☐Rash 発疹 ☐Swelling むくみ ☐Lump しこり

☐Fatigue 疲れやすい ☐Tumor 腫瘤 ☐Painful urination 排尿痛

☐Other（please write）他_____

How long have you had these symptoms？どのくらい

_____Hour(s)時間 _____day(s)日間 _____week(s)週間 _____month(s)ヶ月 _____year(s)年間

Illness and Surgical History 既往歴、手術歴

Mark all past illnesses you have had. 該当する疾患に印をつけてください。

☐High blood pressure 高血圧 ☐Kidney disease 腎臓病 ☐Convulsion or Epilepsy けいれん

☐Diabetes 糖尿病 ☐Liver disease 肝臓病 ☐Tuberculosis 結核

☐Heart disease 心疾患 ☐Thyroid problems 甲状腺異常 ☐AIDS エイズ

☐Hepatitis B or C B/C 型肝炎 ☐Cerebrovascular discase 脳血管疾患

☐Asthma 喘息

☐Other (please write)他_____

Previous surgeries 手術歴 No☐ Yes☐→What/when?_____

Blood transfusions 輸血歴 No☐ Yes☐→What was it for?_____

Family History 家族歴

Mark all illnesses within your immediate family. 血族での

☐High blood pressure 高血圧 ☐Kidney disease 腎臓病 ☐Cancer 癌

☐Diabetes 糖尿病 ☐Liver disease 肝臓病 ☐Genetic illnesses 遺伝子関連疾患

☐Other(please write)他_____

Allergies アレルギー

Do you have any allergies（to medicine, food, other)? アレルギーの有無（薬、食べ物、他）

No□　Yes□→What? 何に_____

Have you had side effects caused by medicine?薬の副作用の有無

No□　Yes□→Which medicine?薬名_____

Have you had problems after having a local or general anesthesia?全身又は局所麻酔歴

No□　Yes□→What?何に_____

Questions for Women 女性への質問

Are you pregnant?　No□　Yes□　Not sure□わからない

Are you currently breastfeeding?今、授乳中ですか　No□　Yes□

Are you taking contraceptive pills?今、避妊用のピルを服用してますか　No□　Yes□

Medication 薬

Are you currently taking any prescribed or over-the-counter medicine(s)?今、処方薬又は売薬を服用中？

No□　Yes□→Which medicine(s)?何の薬を_____

Did you bring your medications with you today? 今日、もって来ましたか？ No□　Yes□

Alcohol and Tobacco お酒とタバコ

Do you regularly drink alcohol?お酒を定期的に飲みますか No□　Yes□→How much/ week?

Do you smoke? No□　Yes□→Cigarettes/ day?一日に____本

How long have you been smoking?____Months 月間　____Years 年間

Did you used to smoke?以前に吸ったことありますか？ No□　Yes□→How many/day?一日に____本

When did you stop?_____Months ago ヶ月前　　_____Years ago 年前

Do have Japanese health insurance ?　No□　Yes□

Do you only want treatment for your main medical problem?現在困っている問題の治療のみ希望しますか？　No□　Yes□　Not sure□わからない