

Medical Questionnaire

Phonetic spelling (Furigana):

Name: _____ Male / Female _____

(Not yet in school / Kindergarten / Nursery school / Elementary or junior high school)

Date of Birth: _____ Year _____ Month _____ Day / Age: _____ Years _____ months _____

Weight: _____ kg Body temperature at visit: _____ °C

Address:

Tel:

What symptoms are you concerned about?

- Fever (since _____ Month _____ Day, around _____ AM/PM _____ o'clock, highest about _____ °C)
- Cough (since _____ days ago; time when it is most frequent:
morning / afternoon / evening / during sleep [can sleep / cannot sleep] / all day)
- Runny nose (since _____ days ago; occasional / constant; nasal congestion [can sleep / cannot sleep])
- Pain (head / throat / ear / stomach / other)
- Vomiting or nausea (since _____ Month _____ Day, around _____ AM/PM _____ o'clock, about _____ times)
- Constipation / diarrhea (formed soft stool / muddy / watery)
- Possibility of a contagious disease (chickenpox / mumps / other _____)
- Rash (where on the body: _____)
- Other(_____)

Past or current medical conditions

- Seizures(_____)
- Asthma (current medications: _____)
- Other(_____)

About medications

- Can you take oral medication three times a day? (Yes / No)
- Medication type you can take:
First choice: syrup / powder / tablet / suppository / any
Second choice: syrup / powder / tablet / suppository / any
- Are you currently taking any medications prescribed by another medical institution? (Yes / No)

Other reasons for today's visit

(Progress report / Explanation of test results / Regular prescription / Urine test / Certificates /
Other : _____)