

Medical Questionnaire (KAWAMTO ENT CLINIC)

Patient name		Date of birth	year	month	day
Address					
Phone		Sex	Male Female		
Language		Fever (if you have)	°C		
Employment		Weight (if under 10years old)	kg		

① What symptoms do you have?

Ear(Rt/Lt)	pain, discharge, hearing loss, ringing, dizziness, floating, fullness, itchy, hearing aid, ear wax
Nose	congestion, runny nose, sneezing, loss of sense of smell, pain, post nasal drip, bleeding, hay fever
Throat	cough, phlegm, sore throat, hoarseness, strange taste fullness, snoring,
Other	

② When did the symptoms start?

(_____)

③ Have you previously had any of the diseases listed below?

diabetes, high blood pressure, glaucoma, prostatic hypertrophy, liver disease, kidney disease, heart disease, asthma, thyroid gland disease

(other: _____)

④ Are you currently undergoing treatment for any diseases?

Yes (Disease: _____) No

⑤ Are you allergic to any foods or medications?

Yes (Medication: _____ Food: _____ Other: _____) No

⑥ Are you currently taking any medications?

Yes (_____) No

⑦ Is there a possibility that you are pregnant?

Yes (expected due date: _____) I do not know No

⑧ Are you breastfeeding?

Yes (how old is your baby? _____) No

⑨ Which type of medicine can you take?

any type tablet powder liquid

⑩ Do you want to have a medical fee statement?

Yes No

⑪ Which language do you want us to use?

English only mostly English and partially Japanese Can use Japanese