No.

西條クリニック
SAIJO CLINIC

Medical Questionnaire

Name | Date

Address | Phone number

Date of birth Y / M / D | Age years old | Nationality

Please check the appropriate boxes.

■What brought you here today?

☐Insomnia ☐Lethargic ☐Hyperactive ☐Anxiety or panic attacks ☐Depression
☐Hearing voices when nobody else is present ☐Suicide idea ☐Feeling of being watched
☐Violent ☐More talkative than usual ☐Excitable ☐Loss of consciousness
☐Other ( )

■When did the symptoms start?

Since approximately: Y / M / D

■What is the purpose of your visit today?

☐Diagnosis ☐Treatment ☐Admission to hospital ☐Referral ☐To obtain a medical certificate
☐Second opinion ☐Other ( )

■Have you ever been diagnosed with any of the diseases listed below?

☐Dementia ☐Alcohol or drug dependence ☐Depression ☐Mania
☐Manic–depressive disorder ☐Panic disorder ☐Anxiety disorder ☐Personality disorder
☐Developmental disorder ☐Epilepsy ☐Schizophrentia ☐Mental retardation
☐Attention deficit hyperactivity disroder

■Are you currently undergoing treatment for any diseases?

☐Yes (Disease:) ☐No

■Are you allergic to any foods or medications?

☐Yes (Foods: Medications: Other:) ☐No

■Are you currently taking any medications?

☐Yes ( ) Please show the medications to the doctor later if you have them with you.
☐No

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

☐Gastrointestinal disease ☐Liver disease ☐Heart disease ☐Kidney disease
☐Respiratory disease ☐Blood disease ☐Brain / neurological disease ☐Cancer
☐Thyroid gland disease ☐Diabetes ☐Other ( )

■How old were you when you became ill?

Age: years old

■Do you drink alcohol?

☐Yes (mL/day) ☐No

■Is there a possibility that you are pregnant?

☐Yes (months pregnant) ☐No ☐I do know

■Are you breastfeeding?

☐Yes ☐No

■How did you find out about our clinic?

☐WEB SITE ☐Referral from medical organization ☐Referral from friends or acquaintances
☐Referral from the sick bay in your office ☐other ( )