Medical Sheet

Family Name: _____ Given Name: _____
Sex: Male / Female. Date of Birth (Day/Month/Year):_____
Country of Citizenship:
Contact Tel. number:
Address:〒 _____

Temperature _____ ℃

① Please describe the symptoms.

② When did it start?

③ Have you had any major illness in past?

Hypertension. Diabetes. Hyperlipidemia. Gait. Stroke.
Brain Hemorrhage. Renal function abnormality. Asthma. Tuberculosis.
Prostate hypertrophy. Cancer.

④ Have you had any operation in past?

⑤ Have you been taking medication?

⑥ Do you have any allergies to any drugs?

⑦ Do you smoke?

⑧ Do you drink?

⑨ For only ladies. Are you pregnant?