（医）谷口医院 問診票
Taniguchi Clinic Medical Questionnaire

ID

(year) (month) (day)

		Where are you from?(What is your nationality?)
Name		
Date of birth	( ) year ( ) month ( ) day	( )
Gender	☐ Male ☐ Female ☐ ( )	
Address	〒	
Phone	Mobile phone	E-mail address

● What is wrong with you? (You may talk to a doctor personally)

●Please write down any current illnesses and also past history of illness.

☐hypertention ☐hyper lipidaemia(hyper tirgly ceridemia,hypercholesterolemia) ☐diabetes
☐hyperuricemia ☐tuberculosis(TB) ☐hepatitis B ☐hepatitis C ☐syphilis
☐HIV infection ☐headache ☐insomnia ☐melancholy ☐anxiety neurosis
☐bronchial asthma ☐allergic rhinitis ☐allergic conjunctivitis ☐atopic dermatitis
☐nettle rash ☐foods allergy (causing foods :)
☐a drug rash (causing agent :)
☐chronic gastritis ☐a stomach ulcer ☐a duodenal ulcer ☐irritable bowel synarome(IBS)
☐hyperthyroidism ☐cancer ☐epilepsy
☐the others

●Have you ever been allergic to medications or foods?

Yes (name of a medication : symptoms:)
No

●Are you taking any medication now?

No・Yes → **Please provide your current medication correctly.Some combinations of particular drugs may cause interactions and may also affect your examination.Therefore, in some cases the clinic will not prescribe medication.**
(ex: an internal medicine・inhalant・nose drops・eye drops・external medicine・health foods・supplement)

●Question for women

Are you(May you be)pregnant? (You may talk to a doctor personally.)
☐Yes → ( )months
☐ No → When is your last menstrual period?
Since ( ) For ( )days