Fill out the right side from this line

Chart No.

たぶち耳鼻咽喉科　診察申込書

DATE: / /

Name :	Male ・ female
The Date of Birth :	Age :
Address :	
Telephone Number :	Cellular Phone Number :

medical Interview sheet

temperature ℃

weight kg

Date: / /

1) What is your problem?

ear, nose, mouth, throat, neck, dizziness, others

How does it feel?

( )

When did it start?

( )

2) Have you ever been to another ENT? yes no

What was your problem?( )

3) Do you take any medicine? yes no

What kind of medicine do you take?( )

4) Do you have any allergy to a medicine or a shot? yes no

( )

5) Have you ever had any diseases below?

rash, asthma, heart disease, high blood pressure, kidney trouble,

liver disease, diabetes, gastroenteritis, tuberculosis, others

6) Are you pregnant? yes no

Are there any possibility to be pregnant? yes no

Please tell us if you have high fever, pain or infectious disease

(parotitis, measles, infuruenza, others)

Signature ____________________