

We ask patients to fill out a medical questionnaire in order to better understand their condition.

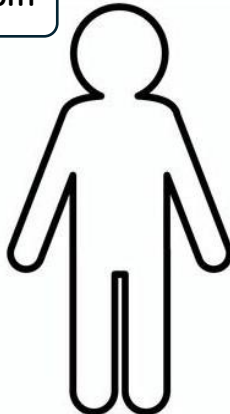
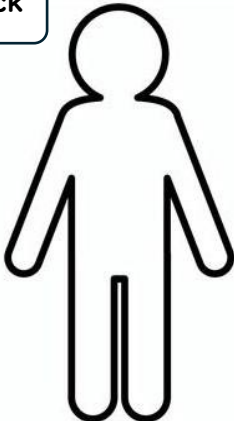
Please check the appropriate boxes or fill in the relevant sections for the questions below.

You may leave any items blank if you prefer not to answer.

Please note that similar or more detailed questions may be asked again by each department during your consultation. We appreciate your understanding and cooperation.

NTT Medical Center Tokyo

Patient ID (7 digits) :			
Name :			
Date of Birth :	Year/	Month/	Date
Phone Number :	—	—	
E-mail Address :			

1	Hight	cm
2	Weight	kg
3	Please describe your current symptoms.	
4	When did the symptoms start?	Since Year/ Month/ Date
5	Circle the area(s) where you feel the symptoms.	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> <div style="border: 1px solid black; border-radius: 10px; padding: 2px 5px; margin-bottom: 5px;">Front</div>  </div> <div style="text-align: center;"> <div style="border: 1px solid black; border-radius: 10px; padding: 2px 5px; margin-bottom: 5px;">Back</div>  </div> </div>
6	Did the symptoms appear suddenly, or did they develop gradually?	<input type="checkbox"/> Suddenly appear <input type="checkbox"/> Gradually appear <input type="checkbox"/> No symptoms
7	Are there any possible causes or triggers you can think of for the symptoms? If not, please write 'None'.	
8	Please describe any recent changes in the symptoms.	<input type="checkbox"/> No changes <input type="checkbox"/> Worsening <input type="checkbox"/> Improving <input type="checkbox"/> No symptoms at present (Resolved)

9	Please circle the number that best describes how severe the symptoms are (0 = none, 10 = unbearable).	0 1 2 3 4 5 6 7 8 9 10																																				
10	Have you visited any other medical facility for the symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No																																				
11	If yes, write the diagnosis you received.																																					
12	What medications are you currently taking? Please provide as much detail as possible. (e.g., Amlodipine 5mg, 1 tablet after breakfast) If you are not taking any medications, please write 'None'.																																					
13	Have you had any illnesses or surgeries in the past? Please list the name of the condition, your age at the time, and whether or not you had surgery.	<input type="checkbox"/> N/A <table border="1"> <thead> <tr> <th>Name of Disease</th> <th>Age</th> <th>Did you have surgery?</th> </tr> </thead> <tbody> <tr> <td>Hypertension</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Diabetes</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cancer</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Heart disease</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Kidney disease</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Liver disease</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Asthma</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Cerebral infarction / hemorrhage</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Prostate enlargement</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Glaucoma</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Others (Name of disease) ()</td> <td></td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </tbody> </table>	Name of Disease	Age	Did you have surgery?	Hypertension		<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes		<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer		<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma		<input type="checkbox"/> Yes <input type="checkbox"/> No	Cerebral infarction / hemorrhage		<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate enlargement		<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma		<input type="checkbox"/> Yes <input type="checkbox"/> No	Others (Name of disease) ()		<input type="checkbox"/> Yes <input type="checkbox"/> No
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14	Have any members of your immediate family ever been diagnosed with hypertension, diabetes, cancer, heart disease, liver disease, cerebral infarction, cerebral hemorrhage, etc.? If so, please specify their relationship to you and the name of the diseases.																																					
15	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> Quit smoking <input type="checkbox"/> Never smoked																																				
16	If you smoke, at what age did you start smoking, and how many cigarettes do you smoke per day?	At _____ years old, _____ cigarettes/day																																				
17	If you quit smoking, at what age did you quit?	At _____ years old																																				
18	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> Never drunk <input type="checkbox"/> Stop drinking																																				

