Interview Sheet

y/m/d / /

＊Please fill in all blanks in order to let us know about your conditions properly.

Name BT ℃ Hight cm
Weight Kg

Address 〒

Phone Number(Mobile phone)

Emergency contact Name Relationship ( )
Phone number

Q1 What is your purpose to visit ?

☐Sick
▼What are your symptoms? Please fill ✓ if you have these symptoms

☐Fever ☐Malaise
☐Neurological (☐Headache ☐Vertigo/Dizziness ☐Shaking ☐Numbness ☐Weakness)
☐Respiratory (☐Sore throat ☐Running nose ☐Cough ☐Sputum ☐Shortness of breath)
☐Chest (☐Chest pain ☐Tachycardia/Palpitation ☐Arrythmia)
☐Gastrointestinal (☐Nausea/Vomiting ☐Stomachache ☐Abdominal pain ☐Diarrhea ☐Blood in stool)
☐Urological (☐Frequent urination ☐Pain during urination ☐Residual urine ☐Blood in urine)
☐Orthopedics (☐Neck pain ☐Shoulder pain ☐Back pain ☐Knee pain)
☐Others Please write down about your symptoms in detail
( )

☐Acupuncture →Have you ever received acupuncture before?_ ☐Yes ☐No
☐Check-up ☐IV injection (outside insurance) ☐Vaccination

Q2 When did the symptom first appear ?

☐Today ☐Several days ago ☐a week ago ☐a month ago ☐over a month ago

Q3 Do your symptoms change within the same day ?

☐Yes ☐No change(constant)

Q4 Are you currently taking any medication or supplements ?

Q5 Do you have any allergy ?

☐Yes Food( ) /Symptoms ☐Rash/itch ☐Difficulty breathing ☐Diarrhea/vomit ☐Others( )
Medicine( )/Symptoms ☐Rash/itch ☐Difficulty breathing ☐Diarrhea/vomit ☐Others( )
Others( ) /Symptoms ☐Rash/itch ☐Difficulty breathing ☐Diarrhea/vomit ☐Others( )
☐No

Q6 Have you suffered any illness that required regular treatment or hospitalization? Please indicate all that apply.

☐None

☐Yes

When	Diagnosis	Hospital	Treatment	Outcome
				Cure/Under treatment/others
				Cure/Under treatment/others
				Cure/Under treatment/others
				Cure/Under treatment/others
				Cure/Under treatment/others

Q7 Have you ever received any surgery?

☐No

☐Yes

When	Diagnosis	Hospital

Have you ever had a blood transfusion?

☐No

☐Yes ( )year-old

Q8 Let us know about your daily habit.

＊Do you drink? ☐No ☐Yes How much do you drink? (What How much)

How often do you drink? ☐Everyday ☐2-4times/week ☐2-4times/month

＊Do you smoke? ☐Never ☐Quit (/day from ～ year-old)

☐smoking (/day from year-old)

＊Do you have any of these diseases?

☐Diabetes ☐Hypertension ☐Dyslipidemia ☐Chronic kidney disease ☐Osteoporosis

＊Do you get any regular health check-up ? ☐No ☐Yes

Q9(Female only) Are you pregnant or is there a possibility of pregnancy? ☐Yes ☐No

Are you currently breastfeeding? ☐Yes ☐No

Thank you for your cooperation.

Sauge Yamashita-cho Clinic