Health Questionnaire

I will be aware of your health condition and use it as a reference for treatment. This information will not be disclosed to anyone other than medical personnel. Please ensure that you or your guardian provide accurate responses.

Date Y M D

SEX

Name _____ Date of Birth Y M D

AGE

Address 〒 -

For apartments or condominiums, please provide the room number as well

TEL _____ Occupation _____

Referrer: _____

☆ **Please briefly describe the reason for your visit today.**

_____

☆ **Please read the questions carefully and circle(○) the applicable ones**

1. Have you received a health checkup within the past year? YES ・ NO

2. Have you ever experienced significant illnesses such as hospitalization or surgery in the past? YES ・ NO

3. Are you currently making regular visits to a hospital?
   If you have a primary care physician, please write their name YES ・ NO
   Hospital Name (Department) _____ Physician's Name _____

4. Are you currently taking medication regularly? YES ・ NO
   Long-term medications _____

5. Do you have any allergies or sensitivities to medications, foods, or other substances?
   _____ YES ・ NO

6. Have you experienced any unusual reactions (such as discomfort) after receiving oral anesthesia? YES ・ NO

7. This question is for ladies only.
   Are you currently pregnant or is there a possibility that you might be pregnant? YES ・ NO
   Are you currently breastfeeding? YES ・ NO

8. What is your usual blood pressure reading? (If you're unsure, please use the blood pressure monitor in the front.)

(Blood pressure: ／ Are you taking antihypertensive medication? YES ・ NO)

Have you ever had any of the following illnesses?

Please respond with YES・NO for all items A) to J).
(If you answered "Yes," please mark a ○ next to the respective condition.)

A) Cardiovascular disease YES ・ NO

・Angina pectoris ・Myocardial infarction ・Heart failure
・Valvular heart disease ・Congenital heart disease ・Arrhythmia
・Cerebral infarction (stroke) ・Hypertension (high blood pressure)
・Hyperlipidemia (high cholesterol) ・Other
(Do you have a pacemaker? YES・NO)

B) Hepatic Disease YES ・ NO

・Hepatitis B ・Hepatitis C ・Liver cancer ・Others _____

C) Renal Disease YES ・ NO

・Renal insufficiency (Are you undergoing hemodialysis?) YES ・ NO

・Others _____

D) Endocrine Disease YES ・ NO

・Hyperthyroidism ・Adrenal Insufficiency ・Diabetes ・Others _____

E) Respiratory System Disease YES ・ NO

・Sinusitis (Sinus Congestion and Nasal Obstruction) ・Hyperventilation Syndrome

・Others _____

F) Gastrointestinal Disease YES ・ NO

・Gastric Ulcer ・Duodenal Ulcer ・Others _____

G) Neurological and Psychiatric Disease YES ・ NO

・Epilepsy ・Neurosis ・Others _____

H) Hematological Disorders YES ・ NO

・Hemophilia ・Leukemia ・Others _____

I) Allergic Disorders YES ・ NO

・Asthma ・Eczema ・Others _____

J) Others

・HIV ・Osteoporosis ・Others _____

☆ In addition to the questions asked so far, please feel free to write down anything else you would like to convey to your primary doctor.

＊In the case of proxy writing, please provide your name and your relationship with the patient for reference.

Name _____