For Patients Visiting the Department of Psychosomatic Medicine

Name:_____ Age:_____y.o.

Sex: Male ・ Female Marital status: Married / Single/ Divorced/ Bereavement

Occupation:_____ Type of work:_____

Phone Number (Please provide a phone number where we can reach you if necessary) Tel._____

1. Specify the issues you currently face. *Place them in order, from the biggest issue first.

①_____
②_____
③_____
④_____
⑤_____
Others_____
_____

2. Provide background information on the symptoms of the above problems.
(Give details such as when the symptoms started and under what circumstances, any changes in the symptoms, history and results of treatment.)

_____
_____
_____
_____
_____
_____

◆ **How did you hear about our Department of Psychosomatic Internal Medicine?**

_____

3. Have you had any previous serious illness surgery or have you been hospitalized before?

Age	Illness	Hospital where you have been treated	Details of treatment	Results of treatment

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4. Do you have any allergies? Yes ・ No

Medication _____

Food _____

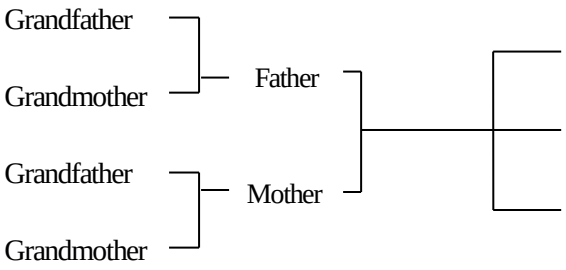
5. List any medications you are currently taking.

_____

_____

_____

6. Complete the following about the structure and medical history of your family.
***Include yourself and any brothers or sisters.**



Relationship with anyone who has the following illnesses

High blood pressure	( )
Stroke	( )
Heart disease	( )
Cancer	( )
Diabetes	( )
Asthma	( )

*** Who was primarily responsible for your upbringing?** (Father / Mother / Other)

7. Last school or employment

_____

_____ (years of continuous service)

8. Daily routine

Time when you get up: _____ Time when you go to bed: _____

Time when you start work: _____ Time when you finish work: _____

Average working hours: _____ Meals: ____ times /day Appetite: good, poor

Smoking habit: _____cigarettes / day, never

Daily alcohol intake: Japanese sake, beer, wine, other_____ml / day, at times, never

Sport or regular exercise: _____ Hobbies: _____

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9. During the past 4weeks, how much have you been bothered by any of the following problems ?

		Not bothered at all	Bothered a little	Bothered a lot
1)	Stomach pain	☐	☐	☐
2)	Back pain	☐	☐	☐
3)	Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
4)	Menstrual cramps or other problems with your periods (women only)	☐	☐	☐
5)	Headaches	☐	☐	☐
6)	Chest pain	☐	☐	☐
7)	Dizziness	☐	☐	☐
8)	Fainting spells	☐	☐	☐
9)	Feeling your heart pound or race	☐	☐	☐
10)	Shortness of breath Palpitations or quick pulse	☐	☐	☐
11)	Pain or problems during sexual intercourse	☐	☐	☐
12)	Constipation, loose bowels, or diarrhea	☐	☐	☐
13)	Nausea, gas, or indigestion	☐	☐	☐
14)	Feeling tired or having low energy	☐	☐	☐
15)	Trouble sleeping	☐	☐	☐

≪PHQ-15 (Patient Health Questionnaire-15) by Kroenke K, Spitzer RL et al 2002≫

10. What is your impression of your current situation? Please include any ideas you might have about possible factors that caused or triggered your symptoms.
(including stress arising from your living environment or personal relationships at home, school or work).

_____

_____

_____

_____

_____

11. How would you like things to change or to change things in the future?

_____

_____

_____

_____

_____

12. At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary. Do you agree to undergo blood transfusion in the event it becomes medically necessary? Yes ・ No

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