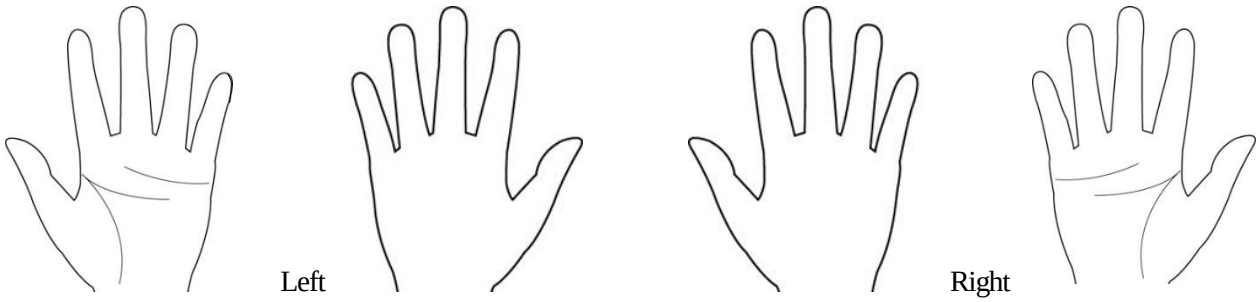
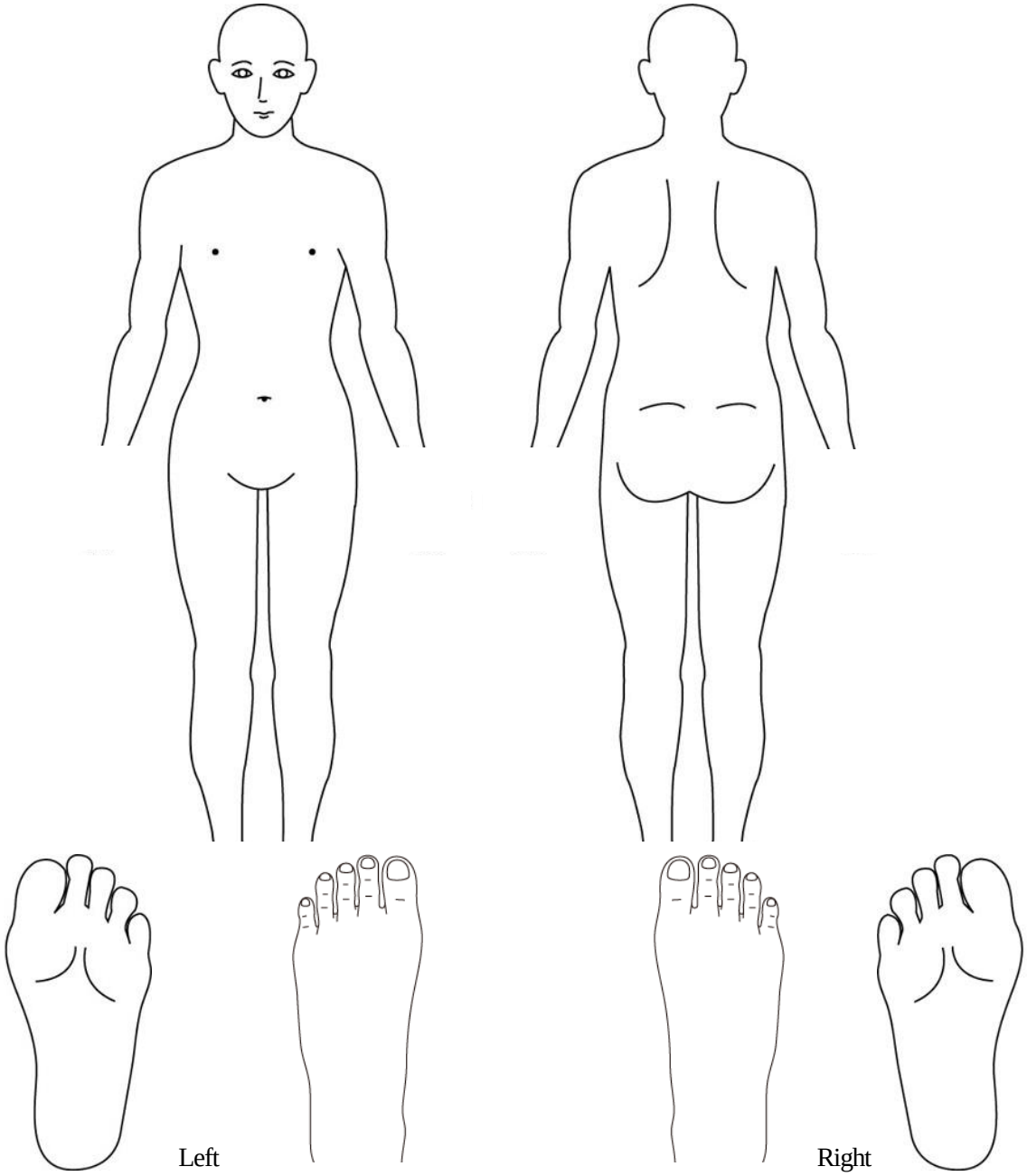
For Those Seeking Dermatology Outpatient Consultation

◆ Please circle the area(s) which you would like to consult about today.





Please also fill out the reverse side.

〒104-8560 東京都中央区明石町 9 番 1 号 Tel.03-3541-5151 Fax. 03-3544-0649

Name: ..... Age: ..... Height: ..... cm Weight: ..... kg

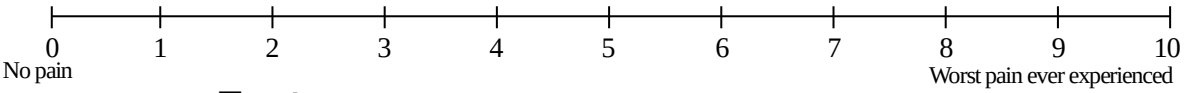
Phone Number: ..... (Please provide a number at which our hospital can reach you when necessary.)

Please answer the following about the symptoms you would like to consult about today.

◆ Since when have you had these symptoms? .....

◆ What kind of symptoms do you have? ☐ itchiness

☐ pain Please circle the value below that corresponds to your level of pain.



☐ rash, eczema

☐ other .....

◆ Are you currently receiving treatment for any of the symptoms above?

☐ YES .....

☐ NO

◆ Have you ever had any of the following conditions?

Allergies/Allergic Reaction	☐ NO	☐ YES	
Asthma	☐ NO	☐ YES	
Diabetes	☐ NO	☐ YES	(☐ oral medication ☐ insulin)
High Blood Pressure	☐ NO	☐ YES	
Surgery	☐ NO	☐ YES	
Possibility of Pregnancy?	☐ NO	☐ YES	
Currently Breastfeeding?	☐ NO	☐ YES	

Do you take any blood thinning (antiplatelet, anticoagulant) medications? ☐ NO ☐ YES

◆ Please list any medications you are currently taking.

◆ Please answer the following questions regarding lifestyle.

History of smoking ☐ NO ☐ YES (..... cigarettes per day for ..... years)

Do you consume alcohol? ☐ NO ☐ YES (..... times per week) ☐ only occasionally

Thank you for your cooperation. Please submit to reception once completed.

SLIH-2016.6.1-Ver.4.00