First Visit Pediatric Patients <HEALTH QUESTIONNAIRE>

Name: M/F Age: y.o Date of Birth: (yy/mm/dd)

Contact Number (where the hospital can call): (Mother/Father/Home/Other)

Sphere of life: Home, ( ) kindergarten, ( ) elementary, ( ) middle school

1. Reason of today's visit. When did it start? Please specify.

2. Please tell us about when your child was born.

- Abnormalities during pregnancy. None Yes ( )
- Gestational Age weeks days (Due date:) Place of birth:
- Delivery: Normal・Forceps・C-section・Other ( ) Admission period days
- Birth weight: g Condition at birth: Good ・ Bad
- Treatment at birth: None ・ Incubator ・ Phototherapy ・ Other ( )
- Abnormalities pointed out at health checkup: None ・ Yes ( )

3. Please tell us the medical history of your child

- Has your child experienced any major diseases, hospitalization or surgery?

When/Name of disease ( )

- Does your child have any allergies? ( )
- Please circle the diseases that your child has had.

	Measles	Rubella	Chickenpox	Mumps	Whooping cough	Asthma	Convulsion	Other( )
Age								

- Please circle the vaccinations your child has had

  BCG ・ DPT-IPV (times) ・ DPT (times) ・ Polio (times) ・ Hib(times)

  Pneumococcus (times) ・ Rota virus ・ Hepatitis B ・ MR ・ Chickenpox ・ Mumps

- Has your child felt ill after receiving vaccination before? ( )

4. Family Structure

Name	Relation	Living together /separately	Date of Birth	Workplace	Occupation	History/Allergy	Nationality
		Living together, separated, bereaved					
		Living together, separated, bereaved					
		Living together, separated, bereaved					
		Living together, separated, bereaved					
		Living together, separated, bereaved					

5. At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary.
Do you agree to undergo blood transfusion? YES NO

Thank you very much. If you are unsure about how to answer some questions, please ask the receptionist.

A nurse will ask about your answers in detail later on. Please wait for a moment.

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