外来問診票　外科

ST. LUKE'S INTERNATIONAL HOSPITAL
OUTPATIENT CLINIC

DATE ____________________

Name ____________________
Family　　　Given

Age ______ Sex ______ ______

Marital Status ____________________

Occupation ____________________

Phone Number Tel: ____________________
(Please provide a phone number we can reach as needed.)

PLEASE ANSWER THE FOLLOWING QUESTIONS, IF NEEDED USE OTHER SIDE.

1. Have you been referred to this hospital by another hospital or physician?　　Yes　　No

2. What is the reason for this visit, and how long have you had these symptoms?

3. Have you ever had any serious illnesses, Injuries, Operations?　Please give dates ad details.

4. Does anyone in your family have the following illness?
   Hypertension　Diabetes Mellitus　Stroke　Heart Attack　Cancer
   Mental Disease　Bronchial Asthma

5. Are you currently taking any medications?　Please give name and dosage.

6. Are you allergic to any medications or pollen?　Please give name.

7. Habits

	Amount per day	How many times per week
Alcohol	______	______
Caffeine(coffee ・ tea ・ cola)	______	______
Smoking	______	______

8. Sleep: approximate time and duration of sleep.

9. Bowel Habits　Regular　Constipated　Loose

10. For Women　Menstrual cycle ______　Date of last period ______　Regular or irregular ______

11. Would you like to mention something else?

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