Medical Questionnaire

Last Name First name		
DOB Year: Month: Day:	Age	Sex ☐ Male ☐ Female
Address in Japan 〒		
Phone No.	Cell Phone No.	
Occupation	HT cm BW Kg BT ℃	
Nationality	Language	

1) What seems to be the problem or purpose of your visit today?
(short of breath, cough, chest pain, leg edema/bulging veins, medical exams, etc.)

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2) Do you have any illnesses noticed by health check or currently under treatment in other hospitals or clinics?

☐ hypertension ☐ diabetes ☐ hyperlipidemia ☐ heart disease ☐ arrhythmia
☐ liver disease ☐ kidney disease ☐ asthma ☐ stroke ☐ cancer ( )
others ( )

3) Have you ever had any illnesses or major injuries or undergone operations before?

☐ No ☐ Yes ( )

4) Are you currently taking any prescribed or over-the-counter medicines?

☐ No ☐ Yes ( )

5) Please select any illnesses your immediate family members currently have or have had in the past.

☐ hypertension ☐ diabetes ☐ heart disease ☐ asthma ☐ stroke ☐ cancer
☐ others( )

6) Have you ever been allergic to anything (food, medicine, others)?

☐ No ☐ Yes( )

7) Do you smoke?

☐ No smoked before but stopped ☐ Yes(pieces /day)( )years

8) Do you drink alcohol?

☐ No ☐ Yes(☐ almost every day ☐ a couple of days a week ☐ once a week
☐ twice a month ☐ less than once a month)

9) Questions for women

Are you pregnant?

☐ No ☐ Yes (month) ☐ Possible

Are you currently breastfeeding?

☐ No ☐ Yes

＊Questions for foreign residents

Are you covered by health insurance?

☐ No ☐ Yes

＊Questions for new patients

How did you know our clinic?

☐ on your way ☐ from your family or friends ☐ flyers or ads ☐ website
☐ referred from other clinics or hospitals ( )
☐ others( )

After you filled this form, please return it to the reception desk.
All information given here is strictly confidential.

OHKADO Heart Clinic
Akihiko Ohkado, MD