Please fill out quetionnaire, if you vist first time or for long tine.

Name	(male / female)	No.	
		Birthday	(YY / MM / DD)
Post No.	—	←Thank you for your filling.	
Address			
Phone No.	— —		

☆What's the matter today? (Where do you have a problem?)

・How long has this bothered you? _____

☆Do you have a fever？ Yes（ ℃）・ No

☆Have you receive any treatment before as shown below. （ Yes↓ ・ No ）

・Asthma ・Food allergy ・Rash out easily
・Diabetes (Hyperglycemia) ・Hypertention ・Hyperlipidemia ・Hypercholesterolemia
・Heart disease ・Arrhythmia ・Cerebral stroke (infarction ・Hemorrhage)
・Gastric ulcer／Duodenal ulcer ・Gatritis
・Glaucoma (Elevated intraocular pressure) ・Cataract ・Prostatic hypertrophy(male)
・Spasm ・Epilepsy ・Febrile convulsion (Child)
・others（⇒ ）

☆Do you take the medicine something now？ （ Yes:what?↓ ・ No ）

☆Do you have any allergy for medication or injection？
Or have you ever had a rash or shock after taking pill or injection?
Yes (what？⇒)・ No

☆Do you have a person who has asthma/febril convulsion/epilepsy in your family?
(Yes・ No ・unknown)

☆For Lady> Are you going to have a baby? Or is there a possibility that you are pregnant?
(No ・ Suspicious ・ pregnant (weeks))

☆For Lady>Are you breast-feeding (Yes・No)

☆For Child> please tell us your weight. _____ Kg

Thank you answer the questionnaire.