

Medical Questionnaire (Orthopedics) / 整形問診

Please check the appropriate boxes.

Patient name/ 患者氏名		Date of birth/ 生年月日 year/ 年 month/ 月 day/ 日	
Sex/ 性別	Age/ 年齢	Height and weight/ cm kg	
Language/ 言語		Nationality/ 国籍	
Address or accommodation in Japan/ 住所 〒			
Phone No.		Speaking Japanese <input type="checkbox"/> Yes <input type="checkbox"/> No Need an interpreter <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employment/ 職業		<input type="checkbox"/> Unemployed/ 無職 <input type="checkbox"/> Retired/ 退職	
Blood pressure/ 血压		Pulse rate 脈拍	Body Temperature 体温

Treatment with health insurance/ 保険診療

Please show your insurance certificate and/or related documents.

Public Japanese health insurance/ 国保・健保

The others (private Japanese health insurance, overseas health insurance, etc.)

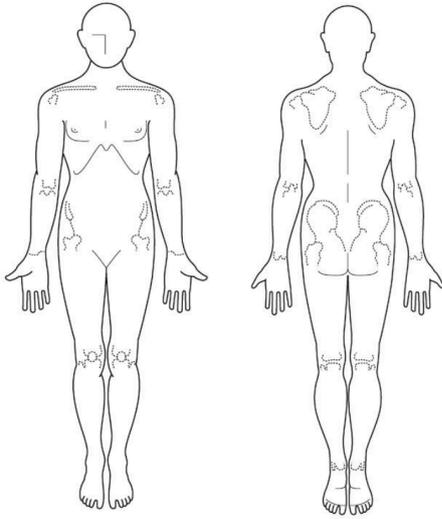
Please contact the insurance institution for the validity of your insurance

Treatment without health insurance/ 自費診療

Please fill in the reverse side of the all pages as well, where necessary.

Where in your body do you have symptoms?/ 部位

Please circle the affected area(s) in the diagram on the right. /



What symptoms do you have?

- Pain/ 痛い Numbness/ しびれ
- Fever/ 熱感 Swelling/ 腫脹
- Injury/ 怪我、外傷
- Lump/ しこり Sprain/ ひねった
- Other/ その他()

When do the symptoms occur?

- Morning/ 朝 Daytime/ 昼 Evening/ 夕方 Night/ 晩
- Constantly/ いつも Irregular/ 不定期 Gradual onset/ 徐々に
- When I feel tired/ 疲労時 When I wake up/ 起床時 While in bed/ 就寝中
- Sudden onset/ 突然 When moving/ 動作時 During meals/ 食事中
- When resting/ 安静時 When walking/ 歩行時
- When moving the affected part/ 動作時 No consistent pattern/ 不特定
- Other/ その他()

When did the symptoms start?/ いつから

Since approximately: year/ 年 month/ 月 day/ 日頃～

Are you currently undergoing treatment for any diseases?/ 現疾患

- Yes (Disease/ 病名:
- No

Are you currently taking any medications?/ 内服薬?

- Yes→ Please show us the medications if you have them with you.
- No

Have you previously had any of the diseases listed below?/

- Gastrointestinal disease/ 胃腸疾患 Liver disease/ 肝疾患 Kidney disease/ 腎臓病
Respiratory disease/ 呼吸器疾患 Brain / neurological disease/ 脳神経疾患
Thyroid gland disease/ 甲状腺 Diabetes/ 糖尿病
Heart disease/ 心疾患 Blood disease/ 血液疾患
Cancer/ 癌 Other/ その他()

How old were you when you became ill?/ 何歳時?

Age: (years old)/ 歳

Do you smoke?/ 喫煙?

Yes/ 吸う → **Current amount**

→ () cigarettes/day/ 本/日 Duration/ 喫煙歴: () years/年

No, but I used to./ 以前吸っていた→**Previous amount**

→ () cigarettes/day/ 本/日 Duration/ 喫煙歴: () years/年

No/ 吸わない

Do you drink alcohol?/ 飲酒. Yes → mL/day/ ml/日 No

Have you ever had any surgery?/ 手術既往 Yes No

When was the surgery?Approximately: year/ 年 month/ 月

type of surgery :

Have you ever had any anesthesia?/ 麻酔歴 No

Yes → General anesthesia/ 全麻 Local anesthesia/ 局麻

Did you have any problems related to the anesthesia?/

Yes () No

Is there a possibility that you are pregnant?/

Yes→ months pregnant/ ヶ月

I do not know/ わからない No

Are you breastfeeding?/ 授乳中 Yes No