MedicalQuestionnaire(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 □Yes □No** **Need an interpreter □Yes □No**	
Employment/ 職業		**□Unemployed/** 無職 **□Retired/** 退職	
Blood pressure/血圧		**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.)

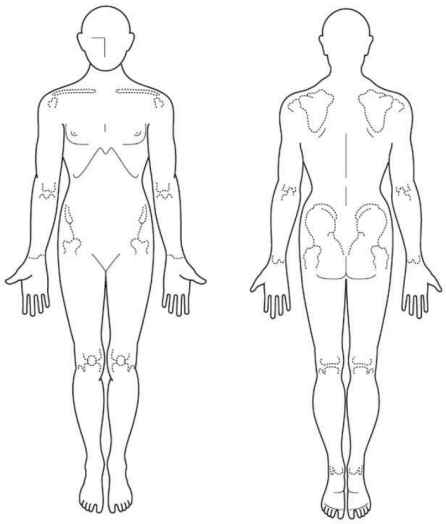
Please contact the insurance institution for the validity of your insurance

☐ 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