

INTERNAL MEDICINE 内科

ID:

Date / /

Name お名前 : _____

・ What are your symptoms? どういった症状ですか？

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・ Are you currently taking medication? 治療されていますか？

Yes → Name of hospital 医療機関名；

Name of disease 病名；

Name of Medicine 処方薬剤；

No

・ Have you ever had any illness or surgery? 病気や手術などの経歴

・ Do you have any food or medication allergies? アレルギー

Yes ()

No

・ Have you ever been a smoker? 喫煙歴

Yes (cigarettes / day) / No

・ Do you drink? 飲酒 Yes (ml / day) / No

・ Are you pregnant or is there a possibility of pregnancy?

妊娠・妊娠中ですか？

Yes / No