

ID: _____

ORTHOPEDECS 整形外科

Date / /

Name 名前 : _____ Height 身長 : _____ cm Weight 体重 : _____ kg

Age 年齢 : _____ years old Dominant hand 利き手 : Right 右 / Left 左

Occupation 職業 : _____ Job requirement 仕事内容 : _____

① Have you had prior illnesses? 今まで病気にかかったことがありますか? Yes / No

Please select any applicable answers from below.

- Cancer 悪性腫瘍 (_____)
- Asthma 喘息 (Recovered 治癒 • Under treatment 治療)
- Childhood asthma 小児喘息 (_____ until years ago)
- Hives due to medication 薬で蕁麻疹 (Name of medicine 薬品名 _____)
- Gastric ulcer 胃潰瘍 (Recovered 治癒 _____ years ago • Under treatment 治療中)
- Other Allergies 薬以外のアレルギー (_____)

② Are you currently undergoing any medical treatment? 治療をされていますか? Yes / No

Please select any applicable answers from below.

- Hypertension 高血圧
- Diabetes 糖尿病
- Liver disease 肝臓疾患
- Heart disease 心臓疾患
- Cerebrovascular disease 脳血管疾患
- High Cholesterol コレステロール
- Glaucoma 緑内障
- Other その他 (_____)

③ Do you have infections disease? 感染性疾患はありますか? Yes / No

Please select any applicable answers from below.

- Hepatitis 肝炎 (_____ type)
- Tuberculosis 結核
- HIV
- Other その他 (_____)

④ Do you take any medications? 服用中のお薬はありますか? Yes / No

If you have a list of your current medications, please let us see it.

- Do you have a medicine notebook? お薬手帳 (Yes / No)
- What Medicine are you taking? 薬の名前 (_____)

⑤ Have you ever had surgery? 手術を受けたことがありますか? Yes / No

If you answered yes, please answer the following questions.

Name of disease : _____ Hospital name : _____

Age : _____ years old OR date of surgery (_____ / _____ / _____)

Name of disease : _____ Hospital name : _____

Age : _____ years old OR date of surgery (_____ / _____ / _____)

⑥ Are you pregnant or is there a possibility of pregnancy? 妊娠・妊娠中 Yes / No

week of pregnancy 何週目ですか? (_____ weeks)

⑦ Are you currently breastfeeding? 授乳中ですか? Yes / No

What is the name of your Obstetrician/Gynecologist? かかりつけ医 (_____)

⑧ Have you ever been a Smoker? 喫煙歴 Yes / No

Continue to back of sheet

⑨ Please mark the area of pain on the human body chart.

痛みの部位を右の人体図に記入してください。

⑩ Since when do you have this pain? いつから痛みますか?

[]

⑪ Is there any cause of pain? Yes / No / Unknown

痛みの原因はありますか?

If you answered yes, please write the cause.

[]

⑫ Do you have fever with the pain? Yes / No

痛みとともに全身の発熱はありますか?

⑬ Does the pain wake you up at night?

就寝中に痛みで目覚める事はありますか?

Yes (Every night 毎晩 ・ Sometimes 時々) / No

⑭ Does any particular motion cause the pain?

どのような動作で痛みが出ますか

[]

⑮ Do you engage in sports? スポーツはしていますか?

Yes (sports : _____) / No

⑯ Questions about exercise. 運動について

I can't exercise due to pain. / I have a pain but I can exercise. / I don't usually exercise.

痛みで運動ができない

痛みはあるが運動はできる

普段から運動はしない

⑰ Please fill in if you visited another hospital for the pain.

痛み（症状）が出てから、他の医療機関を受診された方はご記入ください。

- ・ Hospital name 病院名 : () ・ Department 受診科 ()
- ・ First visit date 初診日 : (/ /) ・ Last visit date 最終受診日 (/ /)
- ・ Diagnosis 診断名 : ()
- ・ Examination 検査 : X-ray / MRI / CT / Blood test 血液検査 / Other その他 ()
- ・ Medication 飲み薬 : Yes (Name of medicine: _____) / No / Unknown
- ・ Medical treatment 処置 : Injection 注射 / Electrotherapy 電気治療 / Traction 牽引 / Massage マッサージ / Fixing 固定 (Cast ギプス ・ Brace 装具 ・ Other その他)
Other その他 ()

⑱ Please select if there is particular type of treatment that you would like.

ご希望される治療方法

Oral or Topical medication / Local injection / Rehabilitation / Leave it up to the doctor

お薬

注射

リハビリ

おまかせ

Left hand

Right hand



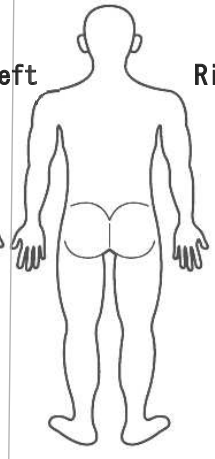
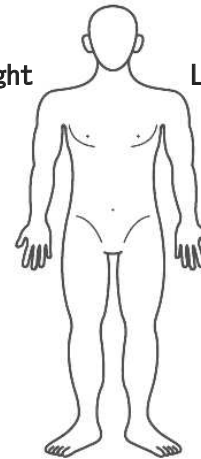
Front

Back

Right

Left

Right



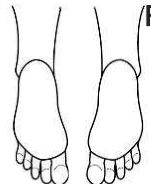
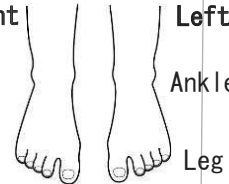
Front

Back

Right

Left

Right



Ankle

Leg