ID:

ORTHOPEDICS 整形外科

Date / /

Name お名前 **:**
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 (/ /)

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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**

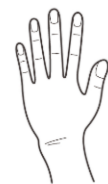
week of pregnancy 何週目ですか? (weeks)

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

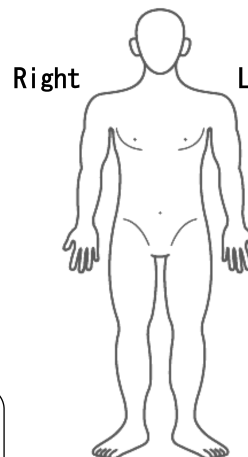
⑩ Since when do you have this pain? いつから痛みますか?

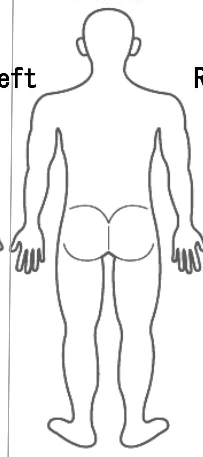
( )

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.

( )





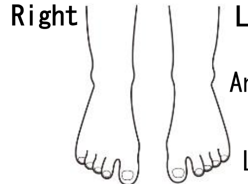
⑫ Do you have fever with the pain? Yes / No
痛みとともに全身の発熱はありますか?

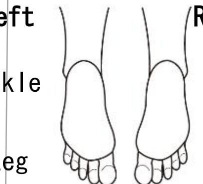
⑬ Does the pain wake you up at night?
就寝中に痛みで目覚める事はありますか?

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 ( )

⑲ 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

整形外科・内科・リハビリテーション科・スポーツ整形
よしおかクリニック

Thank you for your cooperation