Date : / /

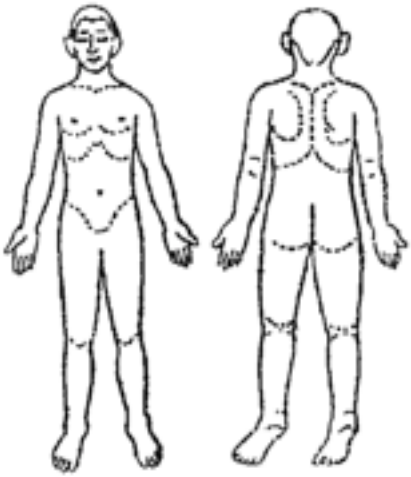
Name : (First name) (Last name)	
Birthday :	Telephone :
Address (In Japan) :	

Medical History Form

※Are you covered by Japanese health insuarance?(YES / NO) ( )

To help us give you the most appropriate diagnosis and treatment,please fill out this form. If you are not sure of any item,simply answer as best as you can.

1 and 2
Please briefly describe the physical problems which bring you here today.
Please mark with a circle the affected zones
→ and the date. (the date :)



3. Have you ever had accidents or injuries?
(YES / NO)

4. What kind of treatment did you recieve?

5. Did you have any medical problems in the past?
(Y ES / NO)

6. Are you taking any medicine? (YES / NO)
If yes,please write the name of your medicine.
( )

7. Do you have any allergies to drugs or foods? (YES / NO)
If yes,please write the name of the medicines or food.
( )

8. How often do you usually drink alchol? (Never / Occasionally / every day)

9. Do you smoke? (YES / NO)
If you do,how many cigarettes a day? ( )

10. What is your occupation?

11. How do you know about our clinic?

at the station / Bulletin board / families / friends / internet
Your company's internal medical offices / Other ( )

Thank you.

MIYAZAKI ORTHOPAEDICS CLINIC ID :