★

Please check(☑)all corresponding answers.　　年　　月　　日

Name _____ ☐ Male ☐ Female

Date of birth: year_____month_____day_____

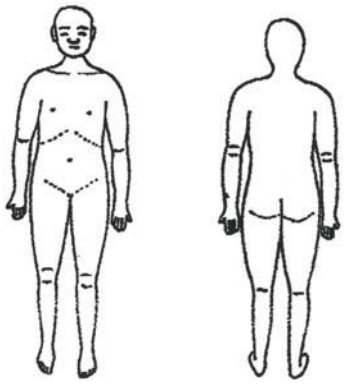
Address _____

Phone _____

Do you have health insurance? ☐ Yes ☐ No

Nationality _____

Circle on the picture below.



■ What is wrong with you?

☐ pain ☐ injury
☐ swelling ☐ lump
☐ numbness ☐ sprain
☐ others( )

＊How long have you had those problems?

Since_____years
_____months
_____days

■ Have you ever been allergic to medication or food?

☐No ☐Yes ⇒ ☐medication( )
☐food( )
☐others( )

■ Are you presently taking medication?

☐ No
☐ Yes ⇒If you have any with you now,please show them to me.

■ What illness have you had in the past?

⇒ ( )

＊Has this disease been cured? ☐ Yes ☐No

■ Questions for women：

＊Are you pregnant or do you have a possibility of pregnancy?

☐No ☐Yes ⇒_____months

＊Are you presently breastfeeding?

☐No ☐Yes

■ Have you ever had any trouble with anesthesia?

☐No ☐Yes