[ ]

Medical questionnaire

/ /2022

Your name (last name first, first name last):_____

Date of birth:_____

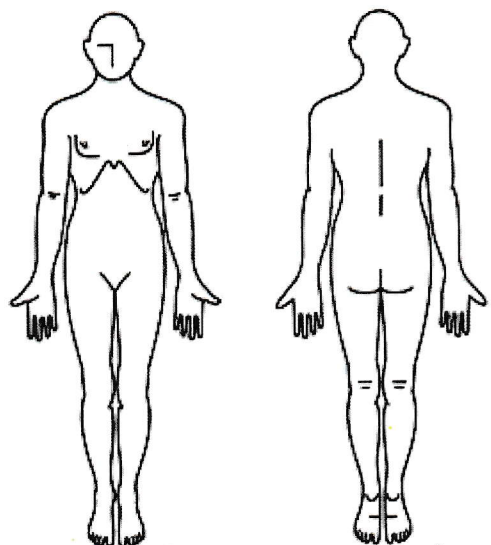
Age:_____ years old/ months old

Occupation_____

Address:_____

Telephone number:_____

Please circle the area you wish to be examined.



How long have you been suffering from your symptoms?

( )

Can you describe your symptoms?

( )

●Have you been on some treatment for the aforementioned symptoms in other medical institutes?

-Yes; please write the detail of the treatment including the content of medication.

( )

-No

●Have you ever experienced serious medical conditions?

-Yes (Your diagnoses:)

If yes, are you on any medication for your illness?

( )

-No

●Are you allergic to anything? (including medications and foods)

-Yes (Do you know the allergen(s)?:)

-No

●Is there a chance that you are pregnant?

-Yes → ( ) week pregnant

-No

●How did you get to know this clinic? (please circle; multiple choices allowed)

-via web search -via direct search of our homepage -brochure

-outside sign of our clinic -recommendation by others

-other ( )