Medical Questionnaire

Date

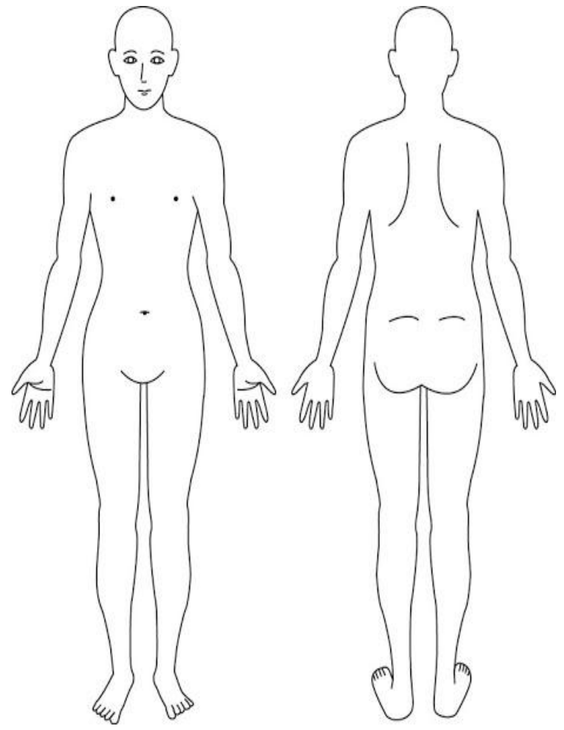
Name		M ・ F	Date of birth Age （　　）	
			Occupation	
Home Address	〒	Home Phone	（　　　　）	
		Cell Phone	（　　　　）	

（1）1.What is your problem today?

Eczema ・ Atopic dermatitis ・ Dry skin ・ Itch ・ Rash ・ Pain ・ Boil ・ Athelete's foot ・ Alopecia ・ Acne ・ Warts ・ Calluses ・ Foot corns ・ Herpes・ Water warts ・ Insect bites ・ Ingrown nails ・ Burn ・ Hay fever ・ Allergy test

If you have any other problem, plz write it down.

Please circle the affected area(s) in the diagram below ↓



①When did it start?

②Have you ever had treatment for symptoms above?

No

Yes　　The Content of Medical Treatment

（2）Have you previously had any other diseases listed below?

No

Yes　　Heart disease　Liver disease　Kidney disorder

Diabetes　High blood pressure　Asthma

Glaucoma　Prostatic hypertrophy

Others

（3）Are you currently taking any medication?

No

Yes　　Name of the disease

Medication

（4）Are you allergic to any Food or Medication?

No

Yes

（5）<Women Only>

Are you pregnant or breastfeeding? Do you have any possibility of being pregnant?

No ・ Yes →　　　month（　　）・ Breastfeeding

Possibility of being pregnant　　Yes ・ No

（6）Please write down how much you weight.

（　　　　）Kg

YAOSAKA Dermatology Clinic