Registration Form & Medical Questionnaire　　ORTHOPEDICS（整形外科・問診票）

Name(名前)			
Date of birth(生年月日)	year　month　day		☐Male ☐Female
Address(住所)	〒(Postal Code)	Prefecture	City
Mobile Phone(携帯電話)			
Emergency contact(緊急連絡先)	Name	Phone	
	Relation (関係)	☐family ☐friend ☐teacher ☐others ( )	
Is this your first visit to this clinic？ (当院は初めてですか。)	☐Yes	☐No(When)	
What is the cause of your problem？ (どうしましたか。)	☐traffic accident (交通事故)	☐injured in business (仕事中のけが)	☐others(その他)
What are your symptoms? (どこが,どのように)	☐injury(けが) ☐sprain(ひねった) ☐pain(痛み) ☐numbness(しびれ) ☐others(その他)		
Where is it hurting now? (今の症状は)			
Do you have any medication allergies? (薬のアレルギー)	☐No	☐Yes(What)	
What illnesses have you had in the past? (過去の病気)	☐Yes(What)		
Are you currently under medical treatment? (現在治療中の病気)	☐Yes(What)		
Are you currently taking medication? (服用中の薬)	☐Yes(What)		

Ikeda clinic 2023～

***Please note**

In the case of using an Individual Number Card as a health insurance card.

① Our clinic strives to provide high-quality medical care by acquiring and utilizing medical information.

② In order to obtain and utilize information, we ask for your cooperation in using your Individual Number Card.

Do you consent to provide us with your medical information?

Yes ☐　　No ☐