聖路加国際病院附属クリニック 聖路加メディローカス
St. Luke's MediLocus

Reception No:
Consultation Date:

GENERAL INTERNAL MEDICINE MEDICAL HISTORY QUESTIONNAIRE

Name: (Last, First, Middle) Male/Female	Age:	Marital status: Single / Married / Divorced / Widowed
	Date of Birth: (Year) / (Month) / (Day)	
	Occupation:	Height: cm / Weight: kg
Please provide a phone number we can reach as needed. Tel:		

1. Please check the reason for your visit today.
   ① ☐ Abnormality was found in the physical checkup. - Please submit your test results if you have any.
   ② ☐ Sick or poor physical condition. - Do you have any symptoms? ☐ Yes ☐ No
   If yes, please write down the details, including WHAT kind of symptoms you have and WHEN they started.
   .....
   .....
   .....
2. Please circle the below number that best averages how difficult the past week has been for you.
   Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely
   To what extent did that difficulty affect your daily life?
   Not at all 0 1 2 3 4 5 6 7 8 9 10 Extremely
3. Have you consulted any doctor about your symptoms recently? If so, please check all that apply.
   ☐ St. Luke's MediLocus ☐ St. Luke's International Hospital (Department: .....)
   ☐ Other hospitals or clinics (Name: .....) ☐ Not visited
   ***If you have visited other hospitals or clinics, please answer the following questions.**
   ① Did you undergo any medical tests?
   ☐ Blood tests ☐ X-ray ☐ ECG ☐ CT scan ☐ MRI ☐ Ultrasound (Echo) ☐ Endoscopy
   ☐ Others: .....
   ② Doctor's comments: .....
   ③ The treatment you received ☐ IV drip infusion ☐ Prescribed medication ☐ Others: .....
4. (For female patients) Please check all that apply.
   ① Menstruation: ☐ Normal ☐ Abnormal ☐ Menopausal ☐ Post delivery
   ② Possibility of Pregnancy: ☐ Yes ☐ No ③ Breastfeeding: ☐ Yes ☐ No

For those who are visiting us for the first time or have had changes in their medical history since their last visit to our clinic or St. Luke's International Hospital, please answer the following questions.

1. Are you taking any medications on a regular basis? If so, please specify all medications and reasons.
   .....
2. Have you ever had any illnesses, hospitalizations, surgeries, or blood transfusions? If so, please check the boxes below.
   ☐ Pneumonia ☐ Appendicitis ☐ Asthma ☐ Tuberculosis ☐ High blood pressure ☐ Diabetes
   ☐ Uterine Myoma ☐ Others: .....

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Tel.03-3527-9520 Fax. 03-3281-5630

3. Have any members of your family (grandparents, parents, brothers, or sisters) had any of the following conditions?

   If so, please indicate your relationship to the family member in the parentheses.

   ☐ High blood pressure (.....) ☐ Heart disease (.....)

   ☐ Cerebrovascular disorders (.....) ☐ Diabetes (.....) ☐ Asthma (.....)

   ☐ Cancer (.....) Type of Cancer (.....)

4. Do you have allergies to any medications or food? If so, Please provide details below.

   ① Medication: ..... ② Food: .....

5. If you drink alcohol, please check and fill in the below.

   ① Main drink: ☐ Beer ☐ Sake ☐ Shochu ☐ Wine ☐ Others .....

   ② How much? _____ ml/day ③ How often? _____ times a week

6. If you have a history of smoking, please write down the details including the past history.

   ☐ Never ☐ Used to ☐ Current How many? _____ cigarettes/day How long? _____ years

7. At this hospital, patients are treated with blood transfusion when deemed medically necessary.

   Do you agree to undergo blood transfusion? ☐ Yes ☐ No

8. Where did you learn about St. Luke's MediLocus?

   ☐ Posters/pamphlets ☐ Homepage ☐ St. Luke's International Hospital ☐ Another medical institution

   ☐ Place of employment ☐ Family/friends ☐ Others: .....

We may use or disclose your health information on an unidentifiable basis for research purposes. We appreciate your understanding.

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