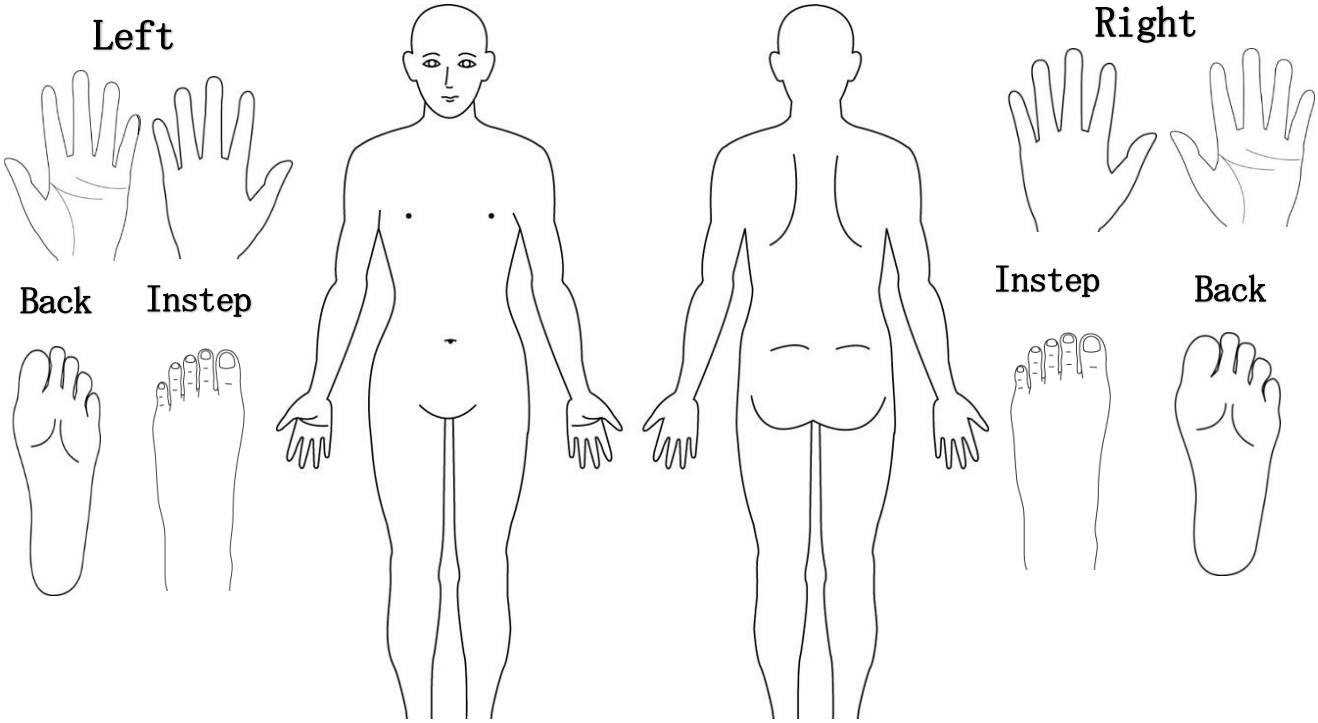
For Those Seeking Dermatology Outpatient Consultation

◆ Please **circle** the area(s) that you would like to consult about today.



◆ Have you brought your medication notebook with you today? ☐ YES ☐ NO

Please list all medications you are currently taking. (Except for medicines of this hospital)

◆ Have you ever had any of the following conditions?

Allergies/Allergic Reaction	☐ NO ☐ YES	High Blood Pressure	☐ NO ☐ YES
Asthma	☐ NO ☐ YES	Possibility of Pregnancy?	☐ NO ☐ YES
Surgery	☐ NO ☐ YES	Currently Breastfeeding?	☐ NO ☐ YES
Diabetes	☐ NO ☐ YES (☐ oral medication ☐ insulin)		

Do you take any blood thinning (antiplatelet, anticoagulant) medications? ☐ NO ☐ YES

◆ At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary.

Do you agree to undergo blood transfusion in the event it becomes medically necessary? ☐ YES ☐ NO

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Please also fill out the **reverse side**.

Name: ..... Age: ..... Height: ..... cm Weight: ..... kg

Phone Number: ..... (Please provide a number where the hospital can reach you when necessary.)

Please answer the following about the symptoms you would like to consult about today.

◆ Since when do you have these symptoms? .....

◆ What kind of symptoms do you have? ☐ Itchiness

☐ Pain Please circle the value below that corresponds to your level of pain.

0 1 2 3 4 5 6 7 8 9 10
No pain — Worst pain ever experienced

☐ Rash, eczema

☐ Others .....

◆ Are you currently receiving treatment for any of the symptoms above?

☐ YES .....

☐ NO

◆ Please answer the below regarding your **mental state**.

(1) Please circle the below number that best averages how difficult the past week has been for you.

0 1 2 3 4 5 6 7 8 9 10
Not at all — Extremely

(2) To what extent did that difficulty affect your daily life?

0 1 2 3 4 5 6 7 8 9 10
Not at all — Extremely

(3) Are you currently undergoing dialysis at this or any other hospital? (Yes / No)

(4) Are you currently pregnant or have you given birth within the past month. (Yes / No)

◆ Please answer the following questions regarding lifestyle.

History of smoking ☐ NO ☐ YES (..... cigarettes per day for ..... years)

Do you consume alcohol? ☐ NO ☐ YES (..... times per week .....) ☐ only occasionally

◆ To objectively evaluate your skin lesions, we may ask to take photos during the examination. ☐ **Confirmed**

If you do not consent to have photos taken of your lesions, please tell the doctor at the time of your consultation.

Thank you for your cooperation. Please submit to reception once completed.

211210_Ver.2.00_A4 白黒両面

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