Outpatient Information Sheet For First-time Patients

Date of record / /

***Please answer the following questions regarding your physical and mental health as completely as possible to assist in an accurate and appropriate health assessment.**

Name		**Completed by**	**(relationship)**
Date of Birth	**(Age)**	**Companion**	**(relationship)**
Address		**TEL**	**( )**
		Emergency Contact	**(relationship)**

1. Have you been diagnosed with any of the following, or are you currently receiving treatment for the following conditions?

High Blood Pressure Diabetes Asthma Glaucoma Hives/Rash

Thyroid-related Disease Epilepsy Cerebral Infarction Heart Disease Cancer Liver disease Kidney disease Gastric/Duodenum ulcer Allergy ( ) Allergy to medicine ( ) Other ( )

2. What are you most concerned about right now? Do you have any symptoms related to it? (Please explain in detail if possible)

3. Please circle any applicable conditions

Headache nausea convulsions numbness shivering/trembling loss of consciousness loss of appetite frustration anxiety palpitations difficulty breathing repetitious movements/actions unable to sleep loss of motivation suicidal thoughts lack of sexual drive don't want to go to workplace/school burdened/lethargic hyper-energetic overly talkative violent make wrong choices depressed feel that everyone is talking about me everyone looks at me weirdly change in personality seeing visions/hallucinations forgetfulness feel a barrier between you and surroundings

4. When did it start Mo / Year (or from what age?)

5. Was there any trigger or cause? Yes / No

If yes, please explain.

6. How do your symptoms affect your daily life in a negative manner?

7. Have you previously received treatment at another hospital/clinic for this symptom?
Yes / No

If yes, please indicate the hospital, period(s) of treatment, whether you were hospitalized or not, and condition diagnosis

Hospital name Department From (mo / yr) to (mo / yr) (In / out patient) (condition / diagnosis)

8. Have you had, or still have any major diseases?

Yes / No

- Early childhood:

- Childhood:

- Young adult or later:

9. Are you taking any prescribed medication? Yes / No

If yes, please list all prescribed medicines. (for patients that have registered their prescribed medicine with the My Number Health Insurance registration, please list any medicine prescribed within 1month.)

10.Do you have any family or relatives that have had psychosomatic, neurological or psychiatric related diseases? Yes / No

If yes, please list them:

Past/Current (Disease:)(Relationship:)

Past/Current (Disease:)(Relationship:)

Past/Current (Disease:)(Relationship:)

11. What kind of personality would you describe as best fits your original personality? Please circle all that apply.

Introvert Quiet Daydreamer Precise Indecisive Short-Tempered Emotional Impulsive Easily Hurt Timid Psychosomatic Nervous Determined Easy-Going Conscientious Selfish Show-off Social Nervous around others Dependent Unaccommodating Low Self-esteem Workaholic Responsible Lively Strong-willed Wild Other( )

12.Life/Upbringing and Education History

(Place of Birth:)

(Institution of Highest level of Education:) (Graduated / Enrolled / Withdrawn)

(Educational Achievements after Elementary School:)

(Month/Year to (Month/year) (Work Description)

(Work History・Work Contents (From: / to /)( )

(Work History・Work Contents (From: / to /)( )

(Work History・Work Contents (From: / to /)( )

(Work History・Work Contents (From: / to /)( )

(Work History・Work Contents (From: / to /)( )

(Work History・Work Contents (From: / to /)( )

Age of Marriage (Years old) (In Love・Arranged・Neither・Single・Divorced)

Who are you currently living with? ( )

Hobbies ( )

Indulgences: Tobacco (_____cigarettes/day / I don't smoke / Quitting)

Alcohol (_____ml/day / I don't drink / Quitting)

(Height: _____cm) (Weight: ____cm)

Have you recently experienced rapid weight gain or loss? Yes / No

13. (For Women Only)

Menstruation Regular / Irregular / Stopped (____ Age)

Are you currently pregnant? Yes (___Month of pregnancy) / No / Possibly

14.Please write your Family Structure and history, focused on your own position (Just the parts that you know is enough).

Father's Siblings

Grandfather (___Age) (_____Age)

(_____Age)

Grandmother (___Age) (_____Age)

Father (_____Age)

Mother's Siblings

Grandfather (___Age) Mother (_____Age) Children

(_____Age) Self (____Age) (____Age)

Grandmother (___Age) (_____Age) (____Age)

(_____Age) Spouse (____Age) (____Age)

15.Do you have a reference letter from another clinic/Institution? Yes / No

16.Have you had an allergic reaction to any foods or medicine in the past?

Please explain the cause and the resulting symptoms

17.Do you give us permission to access Medical Information stored on the MyNumber card when used for Insurance purposes? Yes / No

This clinic tries to provide the most appropriate medical treatment possible through information gathering and use. In order to gather accurate information, we ask for your cooperation in using your MyNumber card for insurance purposes, and allowing access to that information.

Medical Information Acquisition System(First Visit)

Added points 1:4 Added points 2:2 (When using Medical Information Acquisition System)