Date: Year 20___ / ___ / ___

Initial Consultation Application & Medical Questionnaire

Name		Date of Birth		Age		Male・Female
Address	Mobile Phone (　　) — Home Phone (　　) —					
Emergency Contact	Name	Relationship	Contact Number (　　) —			

〔Occupation〕　〔 Hobbies〕　〔Height〕　cm　〔Weight〕 kg

＊ In the past 6 months, my weight has:
☐ Increased by ( ) kg ☐ Decreased by ( ) kg☐ Not changed
※ ☐ Radical Therapy Acknowledged ☐ FACS Acknowledged

＊Please tell us what type of treatment you are seeking at our clinic.
☐Hyperthermia Therapy ☐Immunotherapy ☐Chemotherapy ☐Antioxidant Therapy ☐Undecided

The following section is a medical questionnaire.
Please provide as much detail as possible, as it will help us with your treatment planning.

《 Medical Questionnaire 》

1. About Your Current Illness

※When was your condition diagnosed? (Approx. Date :　　) (At which hospital/clinic?　　) ※What is the diagnosis？

(　　)

※What treatments have you received so far？

a、Have you undergone surgery? (☐Yes ☐No)

b、Are you currently receiving treatment at another hospital or clinic?

(☐Yes ☐No)

(Since (year　　), at

(hospital/clinic　　)

(Department Name:　　)

(Dr :　　)

c、 Are you currently taking medication or receiving injections/IV therapy?
(☐Yes ☐No)
☐ Medication
Name(s)
)
☐ Unknown

2. Have you ever been diagnosed with any of the following conditions?
☐Stomach Ulcer ☐Diabetes ☐Liver Disease ☐Kidney Disease
☐Heart Disease (Heart Attack / Angina) ☐Asthma ☐Tuberculosis
☐Blood Disorder ☐Retinopathy ☐Neurosis / Anxiety Disorder
☐Rheumatism ☐Thyroid Disease ☐Dementia ☐Stroke
☐Collagen Disease / Autoimmune Connective Tissue Disease
☐Others ( )

3. Do you have any of the following implanted in your body? (☐Yes ☐No)

☐Cardiac Pacemaker ☐ Implantable Cardioverter Defibrillator (ICD)
☐Implanted Stimulating Electrodes ☐Cochlear Implant
☐Other
(Specifically:
)

4. If any blood relatives have had the following conditions, please indicate the relationship.
Cancer or Malignant Disease (Who: Name of a disease)
Hypertension ( ) Diabetes ( ) Hepatitis ( )
Heart Disease ( ) Stroke ( ) Asthma ( )
Other)

5. Alcohol & Smoking
※Alcohol Consumption]
☐Drink Daily
How much do you drink per day?
(☐Beer ☐Sake ☐ Whiskey) (glasses/bottles)
☐Drink Occasionally ☐Do Not Drink

※Smoking
☐Currently Smoke Number of cigarettes per day: ( )
☐Used to Smoke (For years / cigarettes per day)
☐Do Not Smoke

6.Allergies

※Do you have allergies or allergic conditions? (□Yes □No)

□Asthma □Hay Fever □Food Allergy □Hives

□Atopic Dermatitis □Allergic Rhinitis □Other (

※Have you ever experienced hives or an allergic reaction after taking medication？

□Yes →Which medication?

( )

□No

7. Infectious Diseases (Medical History)

□Fulminant Hepatitis □Hepatitis B □Hepatitis C □Syphilis

□Other ( )

8. For Female Patients

◇When was your last menstrual period? (Year / Month / Day)

□Menopause

◇Is there a possibility that you are currently pregnant?

(□Yes □No)

◇Have you ever been pregnant?

(□Yes→Number of Deliveries: □No)

9. Lastly, please tell us what led you to visit our clinic for the first time.

□Referral from Another Hospital/Clinic

(Hospital/Clinic: / Department: / Doctor:)

□Books / Magazines

(Name of the Books / Magazines)

□Internet

□Other

( )

✲ Please write any additional requests or comments below.

( )