Weight (　　kg)

	Family name　Given name	male ・ female	Birthday　year　month　day
お名前 Name			
ご住所 Address	〒　－	TEL 電話	

① What sort of symptoms do you have today? What did this start?

② Have you seen any other doctors concerning these symptoms?

③ Do you have any current illness?　Do you take any medication?

④ Do you have any allergy to drugs?

⑤ Is there anything in particular that you wish concerning treatment?

⑥ Smoking　　yes　　no

⑦ Pregnancy　　yes　　no

⑧ Breast-feeding　yes　　no