Nagomu dermatology clinic questionnaire

Date : . .

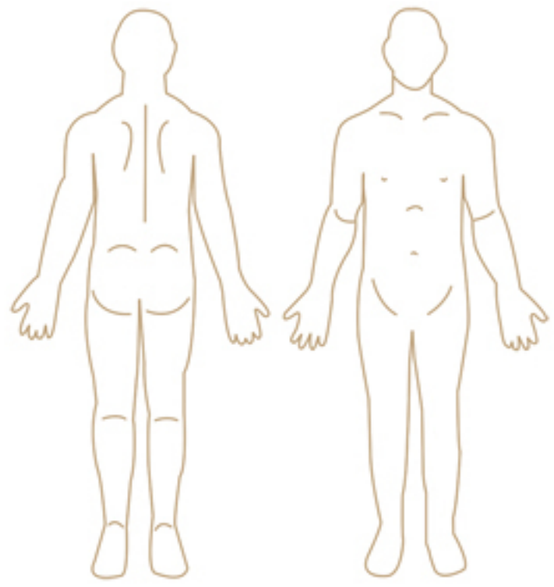
※ The following points are important when choosing Kampo herbal drugs.

Name

Age ( ) Height ( ) Weight ( ) Do you speak (Japanese • English)

What would you like the doctor to do for you?

What are the most troublesome problem(s) for you now?



When did your problem(s) start?

Describe your symptoms.

Family(medical)history

Father's age ( ) : healthy • chronic illness ( ) • deceased (cause of death :)

Mother's age ( ) : healthy • chronic illness ( ) • deceased (cause of death :)

Brothers or sisters (How many :)

Marriage : single • married • separated • divorced • widow / widower

Your spouse's age ( ) :

healthy • not healthy • chronic illness ( ) • passed away (cause of death :)

How many children do you have? : ( )

Medical history

Have you ever been admitted to another hospital? (Hospital's name :)

Which department (were you treated by) ?

Have you ever had an operation? (Yes • No)

Have you had a blood transfusion? (Yes • No)

Do you have a tattoo? (Yes • No)

Have you ever had acupuncture? (Yes • No)

Do you have allergies?

asthma • hay fever • atopic dermatitis • nettle rash • allergy to any medicines

foods (especially cinnamon,papaya,kiwi fruit)

If you take medicines regularly,please give the name. (answer :)

Have you ever taken Kampo medicine before?

(The hospital's name or the pharmacy's name :)

(The name of the kampo medicine :)

Which form of the drug? (liquid • tablet • powder • boil down)

Favorite food

sweet • salty • hot • sour • oily • cold • warm

meat (beef • pork • chicken) • fish (grilled • boiled • raw) • vegetables (raw • boiled)

seaweed • egg • dairy products • fruit • sweets • carbonated brinks : ( )

Please circle your symptoms. please check.

Appetite（good ・ not good）

Sleeping（good ・ a long time needed to fall asleep ・ wake up many times during the night ・ dreaming a lot every day other trouble during sleep）

Urine：（　　）times a day ・（　　）times at night ・ amount of urine（much ・ normal ・ little）

Difficulty in urination ・ Pain on urination ・ Stool：（　　）time(s)（　　）day(s) ・ hard,normal ・ soft ・ diarrhea constipation ・ hemorrhoids ・ Do you use laxatives?（Name：　　）

Other symptoms（Circle your symptoms. please check.）

get tired easily ・ feel depressed ・ forgetfulness ・ irritable ・ sweating easily ・ night sweating ・ headache uncomfortable feeling in the head ・ ringing in the ears (Tinnitus) ・ hard of hearing ・ dizzy when standing up spinning sensation ・ poor eyesight ・ eyestrain ・ trouble focusing ・ dry eyes ・ sneezing ・ runny nose nasal drip in the throat ・ stuffy nose ・ nosebleeds ・ sore throat ・ unable to clear your throat ・ (unusually)thirsty dry mouth ・ chapped lips ・ coughing ・ phlegm ・ short of breath ・ heart palpitations ・ chest pain ・ excess saliva burping ・ heartburn ・ pressure in the stomach ・ nausea ・ vomiting ・ get motion sickness easily ・ stomachache stomach trouble but cannot pass gas ・ excess bowel gas ・ losing sex drive brittle finger nails ・ losing hair ・ dry skin ・ itchy feeling ・ unsteady in walking circulatory problems in the hands ・ stiff fingers in the morning

stiffness：shoulder ・ feet ・back ・ lower back ・ other（　　）

numbness：hands ・ feet ・ other（　　）

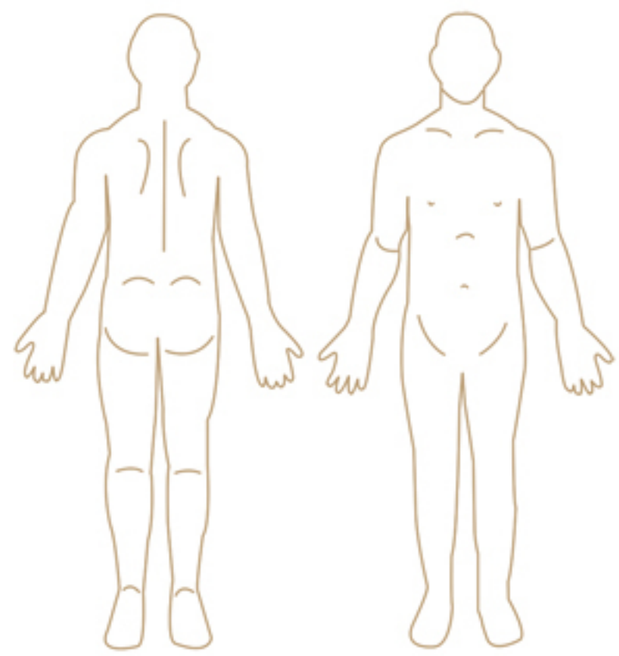
trembling：hand ・ feet ・ other（　　）

feeling chilly：hands ・ feet ・ whole body ・ other（　　）

swollen：hands ・ feet ・ whole body ・ other（　　）

burning sensation：hands ・ feet ・ whole body ・ other（　　）

Please describe any other physical symptoms（　　）



Other

alcohol：what kind ・ quantity（　　）times per week

tobacco：don't smoke ・ smoking（　　）pack(s) per day（　　age to　　age）

coffee ・ black tea ・ Japanese tea ・（　　）cap(s) per day

What makes you to come this clinic?

Internet ・ friends or family ・ magazine ・ passed by（　　）

The following questions are only for women

Menarche（At what age did you first start to menstruate?）：（　　）age ,

Menopause（At what age did you stop menstruating?）：（　　）age ,

Latest period of menstruation（when　　）, Periods of menstruation are（regular ・ irregular）,

Length of menstrual cycle（　　days）, How long do periods of menstruation last?（　　days）,

Quantity of bleed（large ・ normal ・ small）, Is it possible that you are pregnant?（Yes ・ No）,

Do you have pain during menstruation?（before menstruation ・ during menstruation ・ after menstruation）,

（abdominal pain ・ headache ・ or other pain　　）

Do you take any painkillers during menstruation?（If yes, please give the name：　　）

Have you had a miscarriage（naturally or induced）? Have you had an abortion?

hot flashes：hands ・ feet ・ whole body ・ other（　　）