MEDICAL HISTORY QUESTIONNAIRE

Date(DAY/MONTH/YEAR) / / .

NAME	MR. /MISS /MRS. /MS.	
DATE OF BIRTH	DAY/MONTH/YEAR	NATIONALITY
ADDRESS		
PHONE		OCCUPATION
Do you have health insurance?	☐ Yes ☐ No	

① What are your symptoms? Please check or explain.

☐ fever( )℃ ☐ headache ☐ cough ☐ sore throat ☐ weak
☐ nausea ☐ appetite loss ☐ abdominal pain ☐ abdomen feels swollen
☐ bloody stool ☐ constipation ☐ diarrhea ☐stomach ache
☐ chest pain ☐ heart palpitation ☐ shortness of breath ☐ swelling
☐ numbness ☐high blood pressure ☐other

②How long have you had these problems?

③Are you being treated at the present for any medical conditions? ☐Yes ☐No

If so, why?

④Are you taking any medication? If yes, please list. ☐Yes ☐No

⑤Do you have any allergies? If yes, please list using the categories below:

☐Yes ☐No

a)medications

b)foods

c)other

⑥Have you ever had a peculiar or adverse reaction to any medicines or injections?

If yes, please explain. ☐Yes ☐No

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⑦Have you ever had any of the following? Please check.

☐stomach and intestinal disorder ☐liver disease ☐heart disease ☐pacemaker

☐lung disease ☐tuberculosis ☐asthma ☐kidney disease ☐thyroid disease

☐seizures(epilepsy) ☐stroke ☐diabetes ☐high blood pressure ☐cancer

☐AIDS/HIV ☐syphilis ☐drug/alcohol dependency

☐other( )

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⑧Have you ever been hospitalized due to any illness or operations? ☐ Yes ☐ No

If yes, please explain.

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⑨**For women only:**

Are you breastfeeding or pregnant ?

☐ Yes ☐ No ☐ Not sure/May be

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⑩When do you want to make an appointment to see the doctor ?

Please suggest two or three dates that you can come to our clinic.

a)

b)

c)

⑪We will contact you soon to confirm your appointment. How can we contact you?

☐Telephone: ☐E-mail:

Please print and fill out this form, then FAX it to this number;

FAX: (052) 838 7533

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