≪Medical Questionnaire≫

お茶の水甲状腺クリニック
OCHANOMIZU THYROID CLINIC

Name : last / first / middle	Sex

Date of birth year / month / day	Age	Nationality

Address

Phone number

Our clinic strives to provide high-quality medical care by utilizing personal medical information using My Number card.
For obtaining medical information with a My Number card☐ Agree ☐ Disagree

【Check the boxes listed below, if you selected "yes", please answer details.】

Why do you visit our clinic?

☐ detailed examinations ☐ transfer ☐ second opinions
☐ other(s)

Do you have any symptoms?

☐ No ☐ Yes (What symptoms?)

Have you ever received any treatments for thyroid diseases?

☐ No ☐ Yes (When, Diseases:)

Do you have past histories of medical treatments ?

☐ No ☐ Yes (Diseases:)

Are you currently taking any medicines?

☐ No ☐ Yes (Diseases:)

Do you have allergies to any foods or medicines?

☐ No ☐ Yes
Foods ( )
Medicines ( )

Do you have family histories of thyroid diseases?

☐ No ☐ Yes
＊thyroid tumor or cancer (Who:)
＊Hashimoto thyroiditis, Graves diseases (Who:)
＊other(s) (Who, Diseases:)