OCHANOMIZU THYROID CLINIC

≪Medical Questionnaire≫

Name :			Sex
last	first	middle	
/	/		
Date of birth		Age	Nationality
year	month	day	
Address			
Phone number			

【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:)