RafflesMedical OsakaClinic 漢方内科問診票

Name: _____ Body Temperature: _____ ℃

*** Please inform receptionist if you are having high fever or suspected any infectious disease ***

Please answer the questions below

1 What kind of treatment do you wish today?
- ☐ TCM treatment for the existing symptom. 〔 Symptom: 〕
- ☐ To add TCM treatment in addition to the western treatment
- ☐ Second opition for the current TCM treatment

2 Are you currently under any medications? ☐ No ☐ Yes Medications〔 〕

3 Are you allergic to any foods or medications? ☐ Yes ☐ No
Foods / medications 〔 〕

4 Do you drink alcohol? ☐ No ☐ I quited _____ years ago ☐ Yes (_____ ML / time, _____ times / week)

5 Do you smoke? ☐ No ☐ I quited _____ years ago ☐ Yes (_____ cigarettes / day, since _____ years ago)

6 Please tick if you have had any of the symtoms below whithin 3 months. Please ◎ to those which are serious.

Easily fatigued		Sticky mouth		Constipation		Forgetfulness, memory loss	
Laziness		Sneeze		Diarrhea		Armpits pain	
Catch a cold easily		Runny nose, nasal congestion		Dark color with urine		Abdominal distention	
Laziness to talk		Breathe with difficulty		Frequent urination at night		Headache	
Limb cold		Short breathe		Residual urine		Feel heavy-headed	
Limb burning		Wheeze		Urination pain, bloody urine		Dizziness	
Dry skin / lip		Palpitation		Depression / anxiety		Lightheadness	
Sweat easily		Chest pain		Fall asleep with difficulty		Tinnitus	
Pimples		Stuck feeling on chest		Wake often at night		Numbness in limbs	
Fatty oil on forehead		Poor appetite		Get angry easily		Stiffness on hands	
Get thirsty easily		Heavy stomach feeling		Feel irritable		Joint pain	
Under-eye dark circle		Nausea / vomit		Panic		Sole pain	
Sore throat		Heartburn		Flighty, alarmable		Neck-shoulder region pain	
Cough		Belyache		Eyestrain		Backache	
Sputum		Hiccup		Have low energy		Leg swelling	
Other symtoms:							

7 Do you require special consideration in regards of your religion / cultural background?
☐ No ☐ Yes 〔 〕

For ladies only

8 Are you pregnant / possibly pregnant? ☐ Yes ☐ No

9 Are you breastfeeding? ☐ Yes ☐ No

10 Please tick if you have any of the symtoms below.
- ☐ Irregular menses ☐ High menstrual flow ☐ Low menstrual flow ☐ Menstrual cramp
- ☐ Premenstrual headache ☐ Anomalous vaginal fluor ☐ Mammary lump
- ☐ Mammary pain ☐ Nipple secretion

11 Please inform us below.
First menstruation (yo) Last menstruation perioc (～)
Delivery (times) Natural abortion (times) Artificial abortion (times)