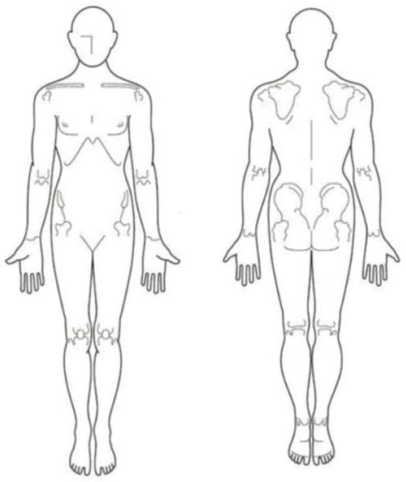
ID :

Orthopedics Questionare

Visit Date	year month day	Temparature	℃
Name	Male Female	Date of Birth	years old Year Month Day
Home adress	〒 ー (phone) ー ー (Cell phne) ー ー		
Height	ｃｍ	Body Weight	ｋｇ

1.What is the probrem today？

Circle the place where you are experiencing the symptom ⇒



When did the symptom strat? years old

Dou you know the cause of the symptom?

☐No cause ☐Others ( )

☐Fall/Injury ☐Labor accident ☐Traffic accident

date of injury year date month

how? ( ) how? ( )

・Describe your symptom

☐Pain (at rest ・motion ・get up・sleep)

symptom like (numbness・sharp ?)

※What does the symptoms occure)

☐Stiffness ☐Swelling ☐Local heat ☐Numbness

☐Abnormal sensation ☐Others ( )

2.If you describe the symptom on a scale of 1-10,how severe is it?Check the number below

0 1 2 3 4 5 6 7 8 9 10

no pain a liitle pain moderate severe pain max pain

3.Have you ever had surgery？

☐No

☐Yes (What surgery?)

4.Implant in your body？

☐No ☐Stent Graft ☐Pacemaker

☐Others ( )

5.Did you traet or exam today sympto※If you say Yes,please write Exam or Drug

☐No ☐Yes ( )

6.Check your past history disease

☐No ☐Athma ☐Gastric or duodenal ulcer

☐HepatitisB or C(continue treatment?or Finished?)

□Diabetic Mellitus □Hypertensior □Cardiac disease

☐Rhumatoid Arthritis ☐Hepatic disease ☐Cerebral infarction

☐Glaucoma☐Prostatic hypertrophy ☐Mental disease

□Osteoporosis ☐Gout ☐その他 ( )

7. Do you have any Medicine？

＊Please show us your medical recordbook

☐No

☐Yes

(Name)

8.Have you been feeling sick due to anesthesia?

☐No ☐Yes

9.Have you been feeling sick due to injection or medicine?

☐No

☐Yes(Please describe) ( )

10.If female, Are you pregnant, or possibly pregnant?

☐No ☐Probably yes ☐Breastfeeding

☐Yes ☐Post Menopausum : Year

11.Do you treat dental disease?

☐No

☐Yes ( )

12.May We take Xray before medical examination?

(My clinc take Xray before medical examination, because save loss of time)

☐Yes ☐No

13.Do you use nursing -care service?

☐No ☐Elderly day car ☐Day care by Physical therapist

・Nersing certificat※「あり」の方は当てはまる数字に〇をつけてください。

☐Yes ☐No Supprt required (1 2)

Long term care (1 2 3 4 5)

Interview sheet for preventing COVID-19 infection expansion

☆All people coming to our hospital, need to fill out this form and bring it reception desk.

Name　　Date　　/y　　/m　　/d

★If you have had any of the following situations, please check(☑)and provide the information

1. Today's your body temparature　　℃
2. Ask >37.5 ℃

When did you have a fever?

3. Did you have a fever within 2 weeks ?
4. Do you use a fever reducer(antipyretic)drug?

Symptom

1. Do you have a sore throat?
2. Do you have a cough?
3. Do you have difficulty in breathing?
4. Do you feel a excessive fatigue?
5. Do you feel a loss of a sense of smell or taste?

Within the past 14days, Did you visit a crowed space, a confined space, and /or had close contact with other people

Within the past 14days, I have visited a foreign country.

( ) return date　　/y　　/m　　/d

Within the 14days, I have been in close contact with a person who has visited a foreign country. Country

( ) return date　　/y　　/m　　/d　country

Within the past 14days, a family member, coworker, ect, has also been in contact with another person who visited a foreign country.

the place where I came into contact with that person ( ) ・circumstance(

※If you're requested to wait in the car, please provide the following:

car model　　(color:　　) number: