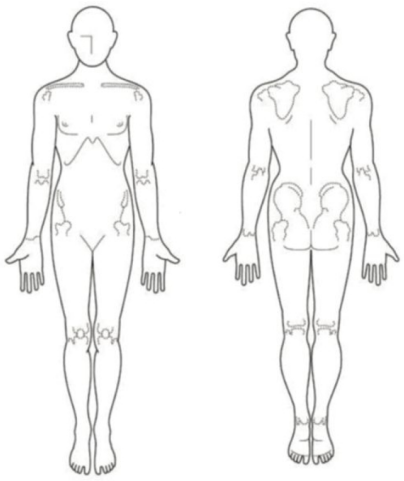
ID：

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 symptor※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)