**Pre-Visit Questions**　　　　Akasaka Family Clinic

Today’s Date：(yyyy/mm/dd) / /

Patient’s Name：　　　　　　　　　　　　　　　　　（Male・Female）　Age

Address：

Contact：Home Phone：　　　　　　　　　　　　Mobile：

　　　　　E-mail：

In case of infant: Nutrition (Breast milk, mix, formula)

　　　　　　 Weaning started at around 　　 months old

Crawling from months old

Walking from　　　　 months old

Speaking words from months old

　　 　　　　 Nursery/Kindergarten from months old

In case of adult: Married, With partner, No partner

　　　　　　Smoking：Yes 、Seized smoking、Never

　　　　　　Alcohol：Everyday, few times a week, occasionally None

　　　　　　Exercise：Everyday, sometimes, None

　　　　　　Occupation：

|  |
| --- |
| 1. Please let us know your current biggest health concern
 |
| 1. Since around when？
 |
| 1. Anything else you would like to consult the doctor about?

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| 1. Any disease or injury in the past?

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| 1. Any allergy? Yes, No

If yes, please describe:　　 |
| 1. Anything you would like to share with the doctor regarding your family member’s medical history?
 |
| 1. Any other comment or question
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Where did you find us? Internet, Friend/Acquaintence/Media/Other