Medical History Form

Name 名前

:

Temperature :	℃
Normal temperature:	℃

Date of Birth 生年月日: Y M D

Age 年齢:

Home Address 住所:

Tel 電話番号 :

Nationality 国籍:

Insurance 保険 : □Japanese public medical insurance 日本の公的保険

□Private Insurance(self paid) プライベート保険（自費） □None なし

【症状 symptom】

□ 熱があります I have a fever（ ℃／since when ）.

□ お腹が痛いです I have a stomach-ache. □ 気分が悪いです I am sick.

□ 下痢が出ます I have a diarrhea. □ 嘔吐しています I am vomiting.

□ 鼻水が出ます I have a runny nose.

□ 咳が出ます I have a cough. □ のどが痛いです I have a pharynx pain.

□ 頭が痛いです I have a head-ache.

□ その他 Others. Please describe the physical problems.

( )

＊COVID-19vaccination history (/ times)

＊Have you traveled from abroad recently? (Yes / No)

When did your problem(s) start? ( )

Have you had any health problems in the past? (yes / no)

If yes, please indicate what the problems were and when you had them:

( )

Is there anyone in your family who has had health problems?

Please explain (and give dates)

( )

If you have any drug or food allergies, please indicate the kind of drugs or the medications or the food:

( )

Do you usually take medicines? (yes / no)

If yes, please describe what they are.

( )

【For women】

Have you been pregnant? (yes / no)

Are you lactating? (yes / no)