Orthopedics patient health questionnaire

Consultation date / /

Name (man ・woman)

Birthday / / ID

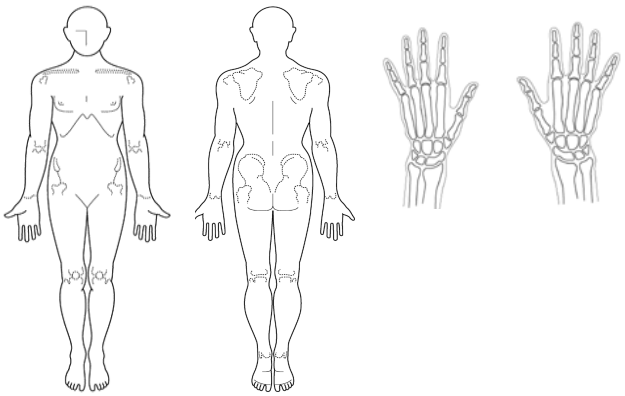
Occupation

Zip-code

Address

Tel ①daytime available

②



1. Describe your symptoms

☐pain ☐numbness ☐swollen

☐move difficulty ☐others

( )

2. When did your symptoms start?

3. Indicate where you have pain or other symptoms

▫neck ▫shoulder ▫elbow/arm ▫back ▫low back ▫pelvis/hip joint ▫knee ▫ankle・foot

4. Did you have an accident to cause symptoms ?

▫sports ▫in daily-life ▫car accident ▫job ▫not special

5. Have you played any sports?

Check numbers

Present	Past

1.soccer 2. Baseball 3.Athletics (middle or long distance) 4. Tennis 5. Golf 6.swimming 7. Ballet/dance 8.bascket ball 9.valley ball 10. Hand ball 11.table tennis 12.gymnastics 13.rhythmic gymnastics 14.cycling 15.figure skate 16.speed skate 17.badminton 18.skiing 19.snowboarding 20.squash 21.triathlon 22.American football 23.rugby 24.archry 25.fencing 26.boxing 27.body-building 28.motor sport 29.wrestling 30.Japanese archery 31.Kendo 32 shooting 33.jyudo 34.weight lifting 35.horse riding 36.water-polo 37.diving 38.athletic (short distance) 39.athletic (jump) 40.athletic (throwing)

6. Did you see any other doctor for this symptoms ?

▫Hospital ▫clinic ▫bonesetter's office ▫massage ▫none

Treatment ▫medication ▫injection

Examination ▫X-ray ▫CT ▫MRI

7. Are you under treatment?

□hypertension □diabetics □heart disease □kidney disease □asthma

□stomach ulcer □others ( ) □None

8. Have you had surgery before?

□No

□Yes Operation name (: year)

9. Are you taking any medicine?

□No

□YES（ ）

10. Do you have any allergy by food or medicine?

☐No

□YES （medicine : 、food ）

11. for women

Are you pregnant？ □No □YES

Are you lactating？ □No □YES

12. How did you know about this clinic?

□TV □internet □magazine □friend □Advertisement □others

（ ）

身長 （ ） 体重（ ）

Bp / P: