QUESTIONNAIRE

HASUHANA KIDS FAMILY CLINIC

For Staff Only

Tempreture ℃
Pulse /min
Blood pressure
／ mmHg
Respiratory Rate ／min
SpO2 %

Name
Address

Phone number

Age years old／ Weight kg
Allergies
☐foods : ☐Medicine :

What is the problem today?
Please check all that apply :
When did it start?

☐Fever :
☐Cough:
☐Runny nose:
☐Diarrhea:
☐Constipation:
☐Vomiting:
☐Abdominal pain:
☐Chest pain:
☐Palpitation:
☐Vertigo:
☐Headache:
☐Rash:
☐Hypertension:
☐Edema:
☐Allergy consultation
☐Abnormality in ECG
☐Abnormality in urinalysis
☐Others:

1. Do you smoke? (Yes/ No)
If you do, how long have you been smoking? (years)

2. How often do you usually drink alcohol?
(never/ occasionally/ every day)

3. Any previous hospitalizations or operations?

4. Are you currently on any medication?

5. Has anyone in your family had disease written in below?

Hypertension ・Stroke・Diabetes・
Acute coronary syndrome/Angina・
Hyperlipidemia・ Cancer