

Clinic ID \_\_\_\_\_ Web Jihi Referred \_\_\_\_\_ Month \_\_\_\_\_ Date \_\_\_\_\_ 20

*Please fill out and make circles following information to help us to know your condition*

Last Name

First Name

Name \_\_\_\_\_, Gender : Male or Female \_\_\_\_\_

カタカナ \_\_\_\_\_

Date of Birth Month \_\_\_\_\_ Date \_\_\_\_\_ year \_\_\_\_\_ Age \_\_\_\_\_ (S:昭和 H:平成 R: 年)

Address 〒 \_\_\_\_\_ How long have you been in Japan? \_\_\_\_\_ years

Where are you from? \_\_\_\_\_ Country \_\_\_\_\_ City \_\_\_\_\_

Phone number ( \_\_\_\_\_ ) \_\_\_\_\_

Health Insurance : Japanese , Others or None \_\_\_\_\_ What kind of it? \_\_\_\_\_

### How did you know us?

- 1 Someone told you about us \*\*\* If you are referred, please show **the referral letter.**
- 2 Through our Home page in Web site. **What words** did you enter for search? Hemorrhoids  
proctology or \_\_\_\_\_, Tokyo \_\_\_\_\_
- 3 Passed our clinic and found us.
- 4 Advertize near Subway ST 5 Advertize in the pole in the street

Did you have any **allergic reaction**? To **what**? \_\_\_\_\_

**What brought you here?** \_\_\_\_\_

Do you have **any medical problem**? What is it? \_\_\_\_\_ Infectious disease? \_\_\_\_\_

**Any medication** you take? What are those? \_\_\_\_\_

**Any serious illness** before? \_\_\_\_\_

**Any surgery** you had before? What surgery \_\_\_\_\_

When \_\_\_\_\_ What hospital \_\_\_\_\_ Where \_\_\_\_\_

### For those who have anus problem

- |   |  |     |    |
|---|--|-----|----|
| 1 | Do you feel <b>pain</b> as bowel movement?                           | Yes | No |
| 2 | <b>Any blood</b> as bowel movement?                                  | Yes | No |
| 3 | <b>Something(hemorrhoids) coming out</b> as bowel movement?          | Yes | No |
|   | If so, do you usually <b>push it back</b> by your fingers or tissue? | Yes | No |
| 4 | Often have <b>diarrhea or constipation</b> ? How often?              |     |    |