

## <Medical Questionnaire>

受診日: 年	月 日	ID:					
Name:		Birthday: / / Age:					
Address: posital o	ode ( -	)					
Phone:		Cell Phone:					
understand the risk facto	·	the staff plan and provide your care, as well as help us with our research to better any parts you are unsure of, or do not wish to answer. We will review the form with ential.					
Reason for visit	□ Breast cancer ch □ Subjective symp						
Please describe the co	urse of your symptoms						
Do you bayo rogular k	proact cancer checkung						
,	reast cancer checkups?						
Examinations received		ry years Other information ( )					
other medical		□Mammography       □Ultra Sonogaphy       □MRI       □Cytodiagnosis         □Needle Biopsy       □Surgery       □Other (       )					
Medical History	Please fill in inform	Please fill in information on your past medical history, etc.					
High blood pressure	□NONE	☐YES: ☐Under treatment ☐Treatment terminated					
Diabetes	□NONE	☐YES: ☐Under treatment ☐Treatment terminated					
Asthma	□NONE	□YES : □Under treatment					
Glaucoma	□NONE	☐YES: ☐Under treatment ☐Treatment terminated					
Allergies	□NONE	☐YES ( ) : ☐Under treatment					
Surgery	□NONE	□YES (       Age: )         □YES (       Age: )					
Smoking	□NONE	☐YES ( ) cigarettes/day ( ) years / ( ) years since quitting					
Alcohol	□NONE	☐YES Amount ( ) ( ) years / ( ) years since quitting					

Gynecological History							
☐ Married ☐ Unmarried	( Partner □YES □NONE	) □Divorced (	Partner □YES □N	ONE) DW	idowed		
Menstruation	Period :   Regular   Irregular   Menopause (age )						
	☐ Artificial menopause ( age )						
Pregnancy/Delivery	Pregnancy : times		Delivery: times				
	☐ Pregnant : months		☐ Possibly pregnant				
Gynecological Diseases	□NONE	□YES	☐Myoma of the u YES ) ☐Endometriosis	iterus (Surg	ery □NONE □		
			□Ovarian Cyst ( □Other ( YES )		ONE □YES ) lery □NONE □		
Breast Feeding History	□NONE	□YES	□Cur	rently breastfo	eeding		
Infertility Treatment	□NONE	□YES ( Period/Frequency			)		
Hormone Replacement Therapy History	□NONE	□YES ( Period/Span		)			
Medication/Supplements	Please indicate all the me	dication you curr	ently take, and whe	n you started	taking them .		
Family History	Please fill in the informati	on of your blood	relatives (Paterna	l and materna	al, up to		
■ Breast Cancer/Ovarian Cancer		Ex. Mother	Breast cancer	Age:60			
Siblings /Children :		Age:			Age:		
Maternal relatives :		Age:			Age:		
Paternal relatives :		Age:			Age:		
<b>■ Other Cancers</b>							
Siblings /Children :		Age:		Age:			
Maternal relatives :		Age:	Age:				
Paternal relatives :		Age:			Age:		
		Nながき乳腺クリニッ NAGAKI BREAST CLI	ック NIC				