



<Medical Questionnaire>

受診日： 年 月 日		ID：
Name:		Birthday: / / Age:
Address: postal code (-)		
Phone: - -	Cell Phone: - -	
<p>■ PLEASE fill in ALL PAGES. Your answer will help the staff plan and provide your care, as well as help us with our research to better understand the risk factors for cancer. Leave blank any parts you are unsure of, or do not wish to answer. We will review the form with you. Any information we gather will be kept confidential.</p>		
Reason for visit	<input type="checkbox"/> Breast cancer checkup <input type="checkbox"/> Subjective symptoms: <input type="checkbox"/> Lump <input type="checkbox"/> Pain <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Other ()	
Please describe the course of your symptoms		
Do you have regular breast cancer checkups? <input type="checkbox"/> YES <input type="checkbox"/> NO		
If you answered YES: From _____(year), every ____ years Other information ()		
Examinations received at other medical	<input type="checkbox"/> Mammography <input type="checkbox"/> Ultra Sonography <input type="checkbox"/> MRI <input type="checkbox"/> Cytodiagnosis <input type="checkbox"/> Needle Biopsy <input type="checkbox"/> Surgery <input type="checkbox"/> Other ()	
Medical History	Please fill in information on your past medical history, etc.	
High blood pressure	<input type="checkbox"/> NONE	<input type="checkbox"/> YES : <input type="checkbox"/> Under treatment <input type="checkbox"/> Treatment terminated
Diabetes	<input type="checkbox"/> NONE	<input type="checkbox"/> YES : <input type="checkbox"/> Under treatment <input type="checkbox"/> Treatment terminated
Asthma	<input type="checkbox"/> NONE	<input type="checkbox"/> YES : <input type="checkbox"/> Under treatment
Glaucoma	<input type="checkbox"/> NONE	<input type="checkbox"/> YES : <input type="checkbox"/> Under treatment <input type="checkbox"/> Treatment terminated
Allergies	<input type="checkbox"/> NONE	<input type="checkbox"/> YES () : <input type="checkbox"/> Under treatment
Surgery	<input type="checkbox"/> NONE	<input type="checkbox"/> YES (Age:)
		<input type="checkbox"/> YES (Age:)
Smoking	<input type="checkbox"/> NONE	<input type="checkbox"/> YES () cigarettes/day () years / () years since quitting
Alcohol	<input type="checkbox"/> NONE	<input type="checkbox"/> YES Amount () () years / () years since quitting

