Questionnaire

ID _____ Date / /

Name _____

Why are you visiting our hospital?

☐ Having any symptoms ☐ Referral from another hospital/clinic

☐ Abnormal findings on the screening test ☐Regular check up

If you have any symptoms, please check all that apply and describe in detail below.

☐Chest pain ☐ Abnormal heartbeats ☐Shortness of breath ☐Swollen legs ☐ Leg pain

☐Other ( )

Are you currently taking any medication?

☐ No ☐If yes, please list:

Are you allergic to any medication, foods or metals?

☐ No ☐If yes, please list:

Do you smoke?

☐ Never ☐I quit(from age ～to age 、 cigarettes/day)

☐ Yes, currently (cigarettes/day, for years)

Do you drink alcohol?

No If yes, (How often? Days a week.

What kind of alcohol? The amount of alcohol)

Do you have now or have you ever had any of the following deseases?

Please check all that apply.

☐Hypertension ☐ Heart disease(Angina, Arrhythmia) ☐ Diabetes ☐ Hyperlipidemia

☐Kidney disease ☐Stroke ☐ Glaucoma ☐Thyroid desease ☐ Gout ☐ Asthma

☐Other( )

Have you ever had any operations before?

Type of operation / reasons for operation	Age at operation
	(years old)
	(years old)
	(years old)

Do you have any family members who had any of the following diseases?

Please check all that apply and indicate the relationship to you in the bracket.

☐ Heart disease ( )

☐ Stroke ( )

＊There are extra questions on the reverse side if you are over 75 years old.

About the burden of hospital visits

How do you get to our clinic and how long does it take?

Transportation

☐Walking ☐Public transportation (subway or bus) ☐Passenger car ☐Others

Escort

☐Spouse ☐Child ☐Others ☐Alone

Required time

☐ Within 30 minutes ☐ 30–60 minutes ☐ 60 minutes or more

If you need to make multiple visits to the hospital for tests,
would you prefer to stay in the hospital for a short period of time?

☐Yes ☐No