

MEDICAL SHEET 問診票

First Name (なまえ) : _____ Family Name (名字) : _____

Male (男) Female (女)

Date of Birth (生年月日) : YYYY/MM/DD _____ / _____ / _____

Age (年齢) : _____ years old

Address (住所) :

Home address in Japan OR address of the place you're staying at OR if you don't know, please write the home address in your home country.

(日本での自宅住所、滞在先住所、それらがない方は祖国の住所をお願いします。)

Telephone (電話) : _____

Mobile phone (携帯) : _____

e-mail: _____ @ _____

☆ Do you have insurance in Japan? (日本での保険はありますか?)

No

Yes

National Health Insurance (国民健康保険)

Social Insurance (社会保険)

Oversea Security Insurance (海外保証保険)

☆ How did you know this clinic? (どのように当店・当院をお知りになりましたか?)

Phone book (電話帳) the Internet (インターネット) Emergency Room (救急医療センター)

Introduction by my family (家族の紹介) Introduction by my friend (友人の紹介)

I went to another shop. (他店への用事) [Marui / SOGO / Sky Building / Other ()]

Station advertisement (駅看板) [JR Line / Sotetsu Line / Keikyu Line / Toyoko Line / Minatomirai Line / Other ()]

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■ 1. Why did you come to this clinic today? (今日はどうなさいましたか?)

Eye Trouble (眼の症状)

- Failure of eyesight (見えにくくなった) [Right / Left / Both]
- Having pain in the eye/s (眼が痛い) [Right / Left / Both]
- Irritable eye/s (ゴロゴロする) [Right / Left / Both]
- Itchy eye/s (眼が痒い) [Right / Left / Both]
- The eye/s got red (眼が赤くなった) [Right / Left / Both]
- Eye mucus (メヤニが出る) [Right / Left / Both]
- Tears (涙っぼい) [Right / Left / Both]
- There is something in the eye/s. (眼にゴミが入った) [Right / Left / Both]
- Swell of eyelid (まぶたの腫れ) [Right / Left / Both]
- I see something black. (黒いものが見える) [Right / Left / Both]
- Dry eye/s (眼が乾く) [Right / Left / Both]
- Tiredness of the eye/s (目が疲れる) [Right / Left / Both]
- Other _____

Purchase (購入)

- I want a new pair of glasses. (メガネをつくりたい)
- I want contact lenses. (コンタクトをつくりたい)
 - First time (初めて) I'm wearing (使用中) [Hard / Soft / 1 month / 2 weeks / 1 day lenses]

Today, I want... (本日も希望のレンズは)

- A. Hard lenses [Loss (紛失) Broken (破損) I want a new pair. (つくり変えたい)]
- B. Soft lenses [Loss (紛失) Broken (破損) I want a new pair. (つくり変えたい)]
- C. 1month / 2 weeks / 1 day lenses
- D. I want to talk with an eye doctor. (医師と相談したい)

Please tell us about the detail of your lenses if you can... (ご使用中のレンズのデータ)

Manufacturer (メーカー) :

[Menicon / Johnson & Johnson / Bausch & Lomb / CIBA / Don't know]

Name: _____

BC (curve) [Right / Left]

PWR (power) [Right / Left]

☆ Under 20 patients/customers (未成年者の方へ) :

Do you have an agreement with your parents about wearing eyeglasses or contact lenses?

(メガネ・コンタクトレンズの使用について保護者の方の同意は得ていますか?) Yes No

Questions continue to the next page...

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- 2. How long have you had the symptom? (お答え頂いた症状はいつ頃からですか?)
- 3. Have you ever had a trouble with using medicine?
(今までに薬を使用して異常があったことがありますか?)
No Yes ()
- 4. Do you wear contact lenses? (普段コンタクトレンズを使用されていますか?)
No Yes (Hard / Soft / 1 month / 2 weeks / 1 day)
- 5. Have you ever had an eye disease? (今まで眼の病気にかかったことがありますか?)
No
Yes: The name of the disease (病名): _____
The name of the clinic (診療所): _____
- 6. Have you ever had an operation with your eye/s or eyelid?
(今までに眼・まぶたの手術をうけたことはありますか?)
No Yes ()
- 7. Currently do you have any illness? (現在の病気は?)
Asthma (喘息) Heart disease (心臓病) High blood pressure (高血圧)
Diabetes (糖尿病) Other ()
- 8. Are you pregnant? OR Do you have a possibility of pregnancy?
(現在妊娠中、又は妊娠の可能性はありますか?)
No Yes (months)

We'll write your clinical record. Please wait in the waiting area. Thank you.