Medical Questionnaire 20 / /

Name Male • Female

Date of Birth / / / (age)

Address or place of stay

Phone No.

■What brings you here today? Please fill in the main ones

Please circle the symptom item

Headache、Vertigo、Dizziness、Neck/Shoulder/Back pain、Other pain

Fever（ ℃）、Sore throat、Cough、Runny Nose、Phlegm、Difficulty Breathing

Abdominal pain、Discomfort、Diarrhea、Constipation

High blood pressure、Palpitations、Chest pain、Irregular heartbrat

Hay fever、Allergies、Itchy body、Eczema、Urticaria、Frequent urination、Cystitis

health checkups、Immunizations

■How long have you had these symptoms? From / /

■Do you have any pre-existing conditions?

■Have you ever been allergic to any medications?

■How did you find out about our clinic?

▫ Web search ▫ Our website ▫ Referred by an acquaintance

▢Other