

**For Patients Visiting the ENT Outpatient Clinic**

|  |  |
| --- | --- |
| Name : | Age : |
|  Email address : | Tel： |

1. **Please specify your symptoms below.**
* What is your main concern?
* From when?
* How?
* Are you in pain? NO ・ YES
1. **Have you been pointed out with any of the following diseases?**

 High blood pressure  Diabetes Asthma  Cardiac disease

 Psychiatric disease  Cerebral infarction Intracerebral hemorrhage None

1. **Have you ever experienced a major disease, hospitalization or surgery?**

NO ・ YES (Name of disease: )

1. **Do you have any allergies to medication?**

NO ・ YES (Name of medication: )

1. **Do you currently take any medications?**

NO ・ YES (Name of medication: )

1. **Do you smoke?**
	* I have never smoked before.
	* I used to smoke: Quit ( ) years ago.
	* I currently smoke: ( ) cigarettes/day× ( ) years.
2. **Do you drink alcohol?**
	* NO
	* YES: (every day, every week, occasionally)

Amount of intake per day: Whiskey (  ) glasses, Beer ( )ml, Wine ( ) glasses

1. **Questions for women.**
	* Are you possibly pregnant? NO ・ YES (pregnancy: months)
	* Are you currently breastfeeding? NO ・ YES

**Thanks for your cooperation!**