

**For Patients Visiting the ENT Outpatient Clinic**

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| --- | --- |
| 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!**