☆★Medical History Form★☆ ☑

Please fill out this sheet. The following information is necessary to ensure a safe and accurate processing of your prescriptions. All information given here is strictly confidential.

1. Are you currently taking any medications? 併用薬
(including non-prescription medicines, eye-drops, health foods, supplements)

☐Yes ⇒If it is already listed in your medical record book, please show us the record or write it below. お薬手帳に書いてある場合は見せて下さい or 記入してください

☐No

＊Would you tell your doctor about your medical history? Drに伝えたか ☐Yes/☐No

2. Have you ever had any illness, or currently have them listed below ? 病歴

☐Yes
☐No

☐High blood pressure 高血圧 ☐Diabetes 糖尿病 ☐Hyperlipidemia 脂質異常症
☐Gout 痛風 ☐Asthma 喘息 ☐Glaucoma 緑内障 ☐Enlarged prostate 前立腺肥大
☐Ulcer 潰瘍 ☐Atopic dermatitis アトピー ☐Others 他 (　　)

3. Are you allergic to any medicines or foods? アレルギー・副作用

☐Yes
☐No

☐Pyrine ピリン ☐Antibiotics 抗生物質 ☐Eggs 卵 ☐Milk 牛乳
☐Others 他 (　　)
＊What kind of symptoms did you have? どんな症状か(　　)

4. Would you tell us your lifestyle because some medicines are taken with caution ?

・Meals 食事 ___time(s) a day
What time? 時間 Breakfast (　:　) Lunch(　:　) Dinner(　:　)
・Do you drink alcohol? 酒 ☐Yes; ___time(s) a week ☐beer ☐wine ☐others ____mL/☐No
・Do you smoke? たばこ ☐Yes; ____cigarettes a day/☐No
・Do you drive a car? 車 ☐Yes/☐No
・Do you operate precision machines? 精密機械 ☐Yes/☐No

5. Do you have any issues or concerns about medication? 困ること気になること

☐Nothing なし ☐Unable to take capsule カプセル ☐Unable to take powdered medicine 粉薬
☐Irregular lifestyle(meals, job, sleep)不規則 ☐Others (　　)

6. Would you like to use Generic Drugs? ジェネリック ☐Yes/☐No

☆ For children
Body weight 体重
____Kg or ____lbs
(1lb=0.45Kg)

☆ For Women
・Are you pregnant?妊娠 ☐Yes(_____months)/☐No
・Are you currently breastfeeding?授乳 ☐Yes/☐No
・Did you tell your doctor? Drに伝えたか ☐Yes/☐No

Address 〒 —	Date of Birth Year: Month: Day:
Name	Phone number

Thank you for taking your time to fill out this sheet.

フォーラル FORALL since1952