Medical Questionnaire

Name	
Date of birth ／ ／ Year Month Day	Age years old
〒 Current Address	
Phone No. ＋ — — — Country code	Emergency contact No. ＋ — — — Country code

What symptoms do you have?

☐Fever ☐Lower back pain ☐Abdominal pain
☐Pain in testicles ☐Pain in penis ☐Difficulty urinating
☐Bloody urine ☐Urinary incontinence ☐Frequent urination
☐Pain when urinating ☐Bedwetting ☐Genital abnormalities
☐Infertility ☐Other ( )

When did the symptoms start?

Since approximately : year_____ month _____ day _____

Are you currently undergoing treatment for any diseases?

☐Yes (Disease : _____)

☐No

Are you allergic to any foods or medications?

☐Yes ☐Medication_____ ☐Food_____ ☐Other_____

☐No

Are you currently taking any medications?

☐Yes

☐No

For women・・・Are you pregnant or possibly pregnant? ☐Yes ☐No

Are you currently breastfeeding? ☐Yes ☐No