



DATE / / /

Outpatient Neurosurgery Initial Consultation Questionnaire

(脳神経外科外来問診票)

Name _____ Age _____ ID _____

☐ male / ☐ Female Height _____ cm / Weight _____ kg / Body Temperature _____ °C

■ What are the main symptoms that you are experiencing.?

(本日来院の主な症状は何ですか)

■ When did these symptoms start?

(症状はいつから始まりましたか)

■ Have you had any major illness, surgery, injury or been hospitalized?

(今までに病気、手術、外傷または入院の経験はありますか)

☐ No ☐ Yes illness : _____

age : _____

■ Do you have any allergies?

(アレルギーは何かありますか)

☐ No • ☐ Yes, to _____

■ Are you currently taking any medication?

(現在何か薬を飲まれていますか)

☐ No ☐ Yes (name of medicine : _____)

■ Do you smoke?

(喫煙しますか)

☐ No ☐ Yes ☐ Used to smoke

(Amount per day: _____、For how long? _____)

■ Do you drink any alcohol? ☐ No ☐ Yes ☐ Used to drink

(お酒は飲みますか)

(Type of alcohol : _____, Amount: _____)

☐ Daily (毎日) ☐ Occasionally (時々) ☐ Few times a month (月に2、3回)

■ For female patients, (女性の方へ)

Are you pregnant at the moment? ☐ No ☐ Yes ☐ Not sure

(現在妊娠していますか)

When was your last menstrual period? (____ / ____)

(最終生理はいつですか)

☐ Menopause

(閉経している)

■ Do you have any medical referral ? ☐ No ☐ Yes

(紹介状はお持ちですか)