Kohno Otolaryngology Medical Sheet

Date: _____

Name: _____ F・M DOB: _____ Age: _____

Address: _____

Phone No.: _____ Mobile: _____

Weight (Only child): _____ kg

What's the trouble?

1. ear: ☐right ☐left ☐both
   pain otorrhea Hard hearing tinnitus Blocked feeling dizziness
2. nose:
   Nasal obstruction Nasal liquid sneeze scentless pain nosebleed
3. throat and mouth:
   pain cough phlegm hoarseness Choked feeling
   Foreign body sense Dryness of intraoral No taste feeling
   Feeling that tongue is strange
4. other:

When did this happen? (For days / weeks)

Do you have a fever? ☐Yes(℃) ☐No

Is there a sickness that has received treatment before now? ☐Yes ☐No

Hypertension Diabetes Bronchial asthma Liver disease
Gastric ulcer Kidney disease Enlarged prostate Glaucoma
Other ( )

Are you taking any medication? ☐Yes ☐No

* Name of medication ( )

Do you have any (medicine, food) allergies? ☐Yes ☐No

* What kind of medicine or food? ( )

Are you pregnant now? ☐Yes ☐No ☐Unknown ☐Suckling

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How did you know this clinic?

☐Signboard in front of clinic ☐Signboard at a railroad station ☐Utility pole signboard
☐Telephone book/Town page ☐Homepage
☐Introduction of another clinic ( )
☐Information from friend, acquaintance, and family