Quesutionaire

ID _____ Date / /

Name _____

Why are you visiting our hospital?

☐ Having any symptoms ☐ Referral from another hospital/clinic

☐ Abnormal findings on the screening test ☐Regular check up

If you have any symptoms, please check all that apply and describe in detail below.

☐Chest Pain ☐ Abnormal heartbeats ☐Shortness of breath ☐Swollen legs ☐ Leg pain

☐Other ( )

_____

_____

Are you currently taking any medication?

☐ No ☐If yes, please list: _____

_____

Are you allegic to any medication, food or metals?

☐ No ☐If yes, please list: _____

_____

Do you smoke?

☐ Never ☐I quit(from age ～to age 、 cigarettes/day)

☐ Yes, currently (cigarettes/day, for years)

Do you drink alcohol?

No If yes, (How often? Days a week. What kind of alcohol?)

Do you have now or have you ever had any of the following desease?

Please check all that apply.

☐Hypertension ☐ Heart disease(Angina, Arrhythmia) ☐ Diabetes ☐ Hyperlipidemia

☐Kidney disease ☐Stroke ☐ Glaucoma ☐Thyroid desease ☐ Gout ☐ Asthma

☐Other( )

Have you ever had any operations before?

Type of operation / reasons for operation Age at operation

_____ (years old)

_____ (years old)

_____ (years old)

Do you have any family member who had any of the following disease?

Please check all that allpy and indicate the relationship to you in the bracket.

☐ Heart disease ( )

☐ Stroke ( )

＊There are extra questions on the next page if you are over 75 years old.

Please answer the questions bellow

1 Has your body weight decreased about 4.5～6.5pounds (2～3kg) within the last 6 months? (Yes / No)

2 Do you feel your walking speed is slower than before? (Yes / No)

3 Do you exsercise like walking more than once a week? (Yes / No)

4 Could you remember the event what you did 5 minutes ago? (Yes / No)

5 Have you felt tired without obvious reason within the last 2 weeks? (Yes / No)