MEDICAL QUESTIONNAIRE

Date: / /

Name	Age	Sex ☐Male ☐Female ☐Others ( )	Position at Kyoto University
Country you are from	Mother tongue		To what extent do you understand Japanese

Who recommended you to come to this place?

☐Yourself ☐Your family/friends ☐Others ( )

What is the purpose of your visit today?

☐Diagnosis ☐Treatment ☐Admission to hospital ☐Referral

☐To obtain a medical certificate ☐Second opinion ☐Others ( )

What symptoms do you have? Please select all applicable answer.

☐Headache	☐Dizziness	☐Nausea
☐Suicidal thoughts	☐Loss of consciousness	☐Difficulty remembering things
☐Feel irritable	☐Feel worried	☐Sadness
☐Verbally abusive	☐Difficulty thinking clearly	☐Lack of appetite
☐Lack of sexual desire	☐Lack of energy	☐Feel heavy
☐Feel depressed	☐Feel unmotivated	☐Stiff shoulders
☐Fainting	☐Ringing in the ears	☐Discomfort
☐Difficulty using words	☐ Feel as if others look at you weirdly	☐Feeling as if something around you has changed
☐Being excited	☐Being aggressive	☐ Being in a manic state
☐Overly talkative	☐Insomnia	☐Awaken during the night
☐Unable to get good sleep	☐Awaken too early in the morning	☐Having nightmares (bad dreams)
☐Low self-esteem	☐Problems in eating foods	☐Self-harm

Please describe your symptoms, anxiety, concerns, etc. without hesitation.

When did the symptoms above occur?

☐( ) years ago ☐( ) months ago ☐( ) week(s) ago ☐( ) days ago

Do you have any thoughts about what might cause the symptoms?

☐No ☐Yes ➡ What might cause your symptoms? ( )

Have you ever received treatment or consultation since the symptoms appeared?

☐No ☐Yes

Where was it? Where did you receive treatment?

( )

Do you have any illnesses currently under treatment?

☐No ☐Yes➡ Name of illnesses ( )

Are you currently taking medication?

☐No ☐Yes➡ Name of medicine ( )

Are you allergic to any food or medication?

☐No ☐Yes➡What are you allergic to? (

Have you ever been diagnosed with any of the diseases listed below?

☐Autism/Asperger syndrome ☐Alcohol or drug dependence ☐Depression ☐Mania

☐Manic-depressive disorder ☐Panic disorder ☐Anxiety disorder ☐Personality disorder

☐Developmental disorder ☐Epilepsy ☐Schizophrenia ☐Mental retardation

☐Attention deficit hyperactivity disorder (ADHD)

☐High Blood Pressure ☐Heart disease ☐Diabetes ☐Liver disease

☐Tuberculosis ☐Injury caused by an accident ☐cerebrovascular disease (stroke)

☐Others ( )

Do you drink ☐No ☐Yes

If yes, what kind of alcohol do you drink? ☐SAKE ☐shochu ☐Beer ☐Whisky ☐Others( )

How much do you drink per day? ( )glass(es)/ day・week・month・year

Do you smoke? ☐No ☐Yes

How many cigarettes do you smoke per day? ( ) /day

To women;

Are you breastfeeding? ☐ No ☐Yes

Are you pregnant, or possibly pregnant? ☐ No ☐Yes ☐ Don't know

About your menstrual period ☐ Regular ☐Irregular ☐Others ( )

Are you mental symptoms related to your Menstruation? ☐ No ☐Yes ☐ Don't know