

平成 年 月 日 Interview Sheet (for first visit)

Address 住所	〒 ー		
Child's name 名前	<input type="checkbox"/> Male 男 <input type="checkbox"/> Female 女		
Date of birth 生年月日	_____ year	_____ month	_____ day
Age年齢	_____ years-old	Weight体重	_____ k g
National Origin 国籍	Language 言葉		
Phone電話番号			

What illnesses have you had in the past? 今までにかかった病気は? <input type="checkbox"/> rubella 風疹 <input type="checkbox"/> Varicella 水痘 <input type="checkbox"/> measles 麻疹 <input type="checkbox"/> mumps おたふく風邪 <input type="checkbox"/> asthma 喘息 <input type="checkbox"/> seizures 熱性けいれん (how long~) <input type="checkbox"/> others その他 ()
Do you have any food or medicine allergies? アレルギーは? <input type="checkbox"/> Yesはい⇒ <input type="checkbox"/> medication 薬 <input type="checkbox"/> egg 卵 <input type="checkbox"/> milk 牛乳 <input type="checkbox"/> others その他 <input type="checkbox"/> NOいいえ
Are you currently taking medicine? 現在飲んでいる薬はありますか? <input type="checkbox"/> Yesはい⇒ If you have any with you now, please show them to me. <input type="checkbox"/> Noいいえ
What kind of oral medicine can you (he, she) take? 薬の種類は? <input type="checkbox"/> syrupシロップ <input type="checkbox"/> powder粉薬 <input type="checkbox"/> tablet or capsule錠剤、カプセル

What are your symptoms? どうしましたか	
(F) <input type="checkbox"/> fever(°C) 発熱	How long have you had these problems? Since () month () day
<input type="checkbox"/> headache 頭痛	Since () month () day
<input type="checkbox"/> cough 咳	Since () month () day
<input type="checkbox"/> stuffiness 鼻がつまる	Since () month () day
<input type="checkbox"/> runny nose 鼻がでる	Since () month () day
<input type="checkbox"/> sore throat 喉が痛い	Since () month () day
<input type="checkbox"/> vomiting 嘔吐(times/day)	Since () month () day
<input type="checkbox"/> nausea 吐き気	Since () month () day
<input type="checkbox"/> diarrhea 下痢(times/day)	Since () month () day
<input type="checkbox"/> bloody stool 血便	Since () month () day
<input type="checkbox"/> abdominal pain 腹痛	Since () month () day
<input type="checkbox"/> constipation 便秘	Since () month () day
<input type="checkbox"/> <u>suspicion of mumps/chickenpox</u> おたふく風邪・水痘の疑い	Since () month () day
eye problems 目の症状	<input type="checkbox"/> mucous discharge めやに <input type="checkbox"/> itching 目の痒み <input type="checkbox"/> hyperemia 充血
skin problems 皮膚の症状	<input type="checkbox"/> rash 発疹 <input type="checkbox"/> dry skin 皮膚の乾燥 How long have you had these problems? Since () month () day
<input type="checkbox"/> others その他	