

■ Do you play any sports?: _____ How often?: _____

■ Do you drink alcohol? How often? (Quantity and kinds): _____

■ Has your family had any serious disease? If yes, what? : _____

■ Why are you interested in Hormone replacement therapy?: _____

■ Do you have any current illness (including chronic disease)? _____

■ Have you ever had any serious disease? If yes, what: _____

■ Have you ever had an operation(including cosmetic surgery)?Yes No

(Details of the operation)

■ Have you ever been anesthetized (including dentist)?..... Yes No

■ Have you ever experienced any ill effects from being anesthetized?.....Yes No

Sudden depression of blood pressure, Nausea, Others() etc.

■ Please circle those which apply to you:

Allergies

(Penicillin, Pillin, Aspirin, Pollen, Asthma, Atopic dermatitis, Allergic conjunctivitis, Others())

Keloid Diathesis

Yes No

Are you currently taking or using any prescription medication or drugs (including supplements)?

.....Yes No

(If yes, What?)

■ Have you had a physical examination within the past 6 months?..... Yes No

■ If yes, was further examination and treatment recommended?..... Yes No

■ Have you experienced any major health problems in the following areas within the past 5 years?

(Please circle all those that apply)

☆ Heart, blood vessel system (high blood pressure, arrhythmia , angina, etc.)

☆ Brain, nervous system (stroke, migraine, epilepsy, etc.)

☆ Lung, trachea system (asthma, swollen tonsils, etc.)

☆ Stomach, intestinal system (ulcer, stomach cancer, etc.)

☆ Liver, gall system (gallstone, cholecystitis, liver dysfunction etc.)

☆ Kidney, urinary organ system (ureteral stone, prostatic hyperplasia, proteinuria etc.)

☆ Ovarian, reproductive system (uterual myoma, overitis etc.)

☆ Breast system (Mastitis, etc.)

☆ Vision and hearing system (Eyes, ears , nose etc.)

- ☆ Bone system (osteoporosis, etc.)
- ☆ Endocrine, metabolism system (diabetes, hyperlipidemia, thyroid disease etc.)
- ☆ Connective tissue disease, autoimmune system (rheumatism etc.)
- ☆ Psychosomatic, mental disorder (depression, chronic fatigue syndrome)
- ☆ Others()

■ Have you ever received a blood transfusion?Yes No

■ When was your last menstrual period?

(Month Day ~ Month Day Number of days:)

■ Is your menstruation regular?Yes No

■ Cycle of period: (days)

■ Do you have an irregular bleeding, besides menstrual periods? Yes No

■ When is your next menstrual periods? (Month Day)

■ Are you pregnant or planning to become pregnancy in the near future?.....Yes No
(Pregnant: weeks)

■ Have you experienced pregnancy, breast-feeding, and birth?Yes No

[If yes, age:]

Normal / Caesarean operation (circle one) Breast-feeding: Yes No (circle one)

■ Has your menstruation stopped because of menopause? If yes, when was it?(year's old)

■ Do you currently have a communicable disease?.....Yes No

■ How did you know about our clinic?()

If website, please write down the search word. ()

■ Do you have an interest in any other matter besides today's consultation?Yes No

1. Aging spots /Freckles 2. Wrinkles 3. Sagging skin (face / body) 4. Acne/Acne scars
5. Open pores 6. Redness 7. Mole 8. Wart 9. Birth mark (Red•Blue) 10. Removal of tattoo , art make-up
11. Little cosmetic surgery (nose•chin) 12. Excessive sweating (armpit•palm)
13. Whitening injection 14. Laser hair removal 15. Others()

■ Would you like to receive the direct mail or email newsletter (including information of new treatment or invitation) from our clinic?

[Both Direct mail & Email Newsletter Direct mail only Email news letters only Neither]

Thank you very much.

Azabu skin clinic