Date of consultation	/ /
Name of patient	
Date of birth	/ /
Sex	

・If your child has a patient card of our clinic, please fill in below.

Clinic ID number	

・If your child does not have a patient card of our clinic, please fill in below.

Zip code	−
Address	
Phone number	− −

For the first visit for the current symptom.

1.) Please describe the current symptoms.

A. What brought you and your child here today? Please circle the symptoms he/she has.

☐ Fever ☐ Cough ☐ Nasal discharge ☐ Wheezing
☐ Diarrhea ☐ Vomiting ☐ Rash ☐ Others（ ）

Pain :
☐ Headache ☐ Earache ☐ Sore throat
☐ Neck pain ☐ Chest pain ☐ Stomachache
☐ Joint pain ☐ Others（ ）

B. Is your child suspected of the infections below? Has he/she been in close contact with anyone who had these infections? Please circle if applicable.

☐ Influenza ☐ Pharyngoconjunctival fever ☐ Varicella
☐ Mumps ☐ Whooping cough ☐ COVID-19

C. Can he/she laugh, play, sleep, eat, or drink as usual? Please circle the

most applicable number. 5 means ‘can do as usual’ and 1 means ‘almost impossible’.

Laugh (5, 4, 3, 2, 1)　Play (5, 4, 3, 2, 1)　Sleep (5, 4, 3, 2, 1)
Eat (5, 4, 3, 2, 1)　Drink (5, 4, 3, 2, 1)

D. Has he/she taken medication for current symptoms?

☐ Yes　☐ No

2.) Please describe other things about your child. If he/she has visited our clinic before, please fill in anything has changed since the last visit.

A. Does he/she have any of the prior major illness? Please fill in if applicable.

☐ Admitted to neonatal intensive care unit（　　）
☐ Treated in the past（　　）
☐ Currently under medical treatment（　　）

B. Does he/she take any medication on a regular basis?

☐ Yes　☐ No

C. Does he/she have any allergy? Please list if applicable.

☐ Medication（　　）
☐ Food（　　）

D. Please list the family members living together with him/her. (eg. mother, father, grandparents, older sister, younger brother. etc)

（　　）

E. Please let us know the name of the nursery school, preschool, or school your child attends, if applicable.

（　　）

Thank you for filling out.