# QUESTIONNAIRE

for the patient of the first visit

NAME: _____

ADRESS: _____

DATE of BIRTH: _____

PHONE NUMBER: _____

Do you have any tendency to develop allergy ? Yes / No

If yes, what is it. _____

If you ever have had, please fill in the blank below:

Operation: _____

Serious Disease or Injury: _____

Currently, do you visit any other medical facilities or under any medical care?

If yes, please write it below:

_____

_____

Do you smoke? No / Yes(_____/day)

Do you drink? No / Yes(_____/day)

Do you drive? No / Yes

For a lady: Is there any possibility you are pregnant? Yes / No

Thank You

SUZUKI CLINIC