

**問　診　票**

【健康増進・アンチエイジング用】

ID：

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ふりがな  **記入者名** |  | 続柄 |  | 記入日 |  | 年 |  | 月 |  | 日 |

**患者様情報**

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| ふりがな  **氏 名** |  | | 男　女 | 生年  月日 | |  | | 年 |  | | | 月 |  | | 日 | |  | 才 | |
| **住 所** | | 〒 | | | TEL | |  | | | - |  | | | - | |  | | |
| 携帯 | |  | | | - |  | | | - | |  | | |
| FAX | |  | | | - |  | | | - | |  | | |
| **緊急連絡先** | | 続柄 | | | TEL | |  | | | - |  | | | - | |  | | |
| (ご本人以外) | | 氏名 | | | 携帯 | |  | | | - |  | | | - | |  | | |

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| **婚姻の状態** | 未婚 | 既婚 | 離婚 | | 未亡人 | | こども | | 無・有 | |  | 人 | **身長** |  | | ㎝ | **体重** |  | ㎏ |
| **家族構成** |  | | | | | | | | | 現在及び以前の**職業** | | | | |  | | | | |
| **現在通院中の病院** | | | 無・有 | | |  | | | | | | | | | | | | | |
| **有の場合病院名：　　　　　　　　　　　　　　　　　病名：** | | | | | | | | | | | | | | | | | | | |
| **既往歴：** | | | | | | | | | | | | | | | | | | | |
| **糖尿病** | 無・有 | | **有の場合インシュリンの使用** 無・有 | | | | | | | | | | | | | | | | |
| **家族の病歴** （特筆する病気があれば続柄と病名）： | | | | | | | | | | | | | | | | | | | |
| **アレルギー疾患** | | 無・有　　食物・金属等： | | | | | | | | | | | | | | | | | |
| **薬物アレルギー** | | 無・有 | | 有の場合薬品名： | | | |  | | | | | | | | | | | |

**現在内服している薬があればご記入ください**

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**現在摂取しているサプリメントがあればご記入ください**

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**相談内容**

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