ID [ ]

MEDICAL REGISTRATION FORM

(DD . MM . YY)

Name		Sex	(Male • Female)
Date of Birth		Age	(year month)
Body Weight	Kg	Body Temperature	℃
Address	〒		
Cell Phone			

What is his/her symptoms?

fever cough runny nose noisy breathing headache sore throat abdominal pain
chest pain vomiting/nausea diarrhea constipation rash itching dizziness
loss of appetite seizures (others)

How long has he/she had these symptoms?

Please describe his/her history of these symptoms in details.

Has he/she seen another doctor for these symptoms before? Yes • No
yes→What was the diagnosis?

Is he/she currently taking any medication? Yes • No
yes→What is it ?

Any allergic reaction? Yes • No
yes→ medication egg milk others food

Any infectious disease going around in your family, school or nursery school?

His/her medical history?
rubella chicken pox measles mumps whooping cough severe rash
asthma atopy allergic rhinitis seizures MCLS（Kawasaki disease） appendicitis
others→

Is he/she currently under medical treatment? Yes • No