# Please fill out the questionnaire

↓ for child under 15

Name male/female Body weight kg

1） Mark the diseases you have ever suffered from in the past with ○.

Or are you under treatment of any diseases now? ⇒ mark them with◎

Myocardial infarction, Angina, Arrhythmia, Hypertension

Asthma, Prostatic hypertrophy, Glaucoma( elevated intraocular pressure),

Diabetes( hyperglycemia ),Gastritis, Gastric ulcer, duodenal ulcer

allergic rhinitis(pollenosis or else ), atopic dermatitis, allergic conjunctivitis

Others: ○(previous dis.)

◎(current dis.)

If you take any medicine now, please describe them below

2） Have you ever experienced any allergic reaction (including rash, hives, itchy throat, hoarseness, asthma and anaphylactic reaction such as choking, dyspnea, faint or shock) when you took any food or medicine? ( yes ・ no )

What happened to you? ( )

What caused that? ( )

Do you have any food or medicine that you can't take?( )

3） Are you pregnant now? ( yes ・ no )⇒ weeks(expected to bear in )

Is there a possibility that you are pregnant? ( yes ・ no ) ⇑what month?

Are you breast-feeding? ( yes ・ no )

4） What is your problem? When did it start?