Please fill out the following form

Name	
Date of Birth	Day Month Year
Address	
Phone	
Allergies	☐Food(s): ☐Medicine:

Your Past History **Please circle**

Asthma	Diabeles	Hypertension
Liver disease	Drug allergy	Hearl disease
Others	Nothing	

What's wrong today? **Please circle**

Ear Right・Left・Both	Earache/耳が痛い	Difficulty hearing/難聴	Ringinng/耳鳴り
	Ear discharge/耳だれ	Clogged ear feeling/耳閉感	
	Foreign body in the ear/耳に物が入った		Dizziness/めまい
Nose Right・Left・Both	Runny nose/鼻水	Nosebleed/鼻血	Sneezing/くしゃみ
	Strong smell/異臭	Nasal congestion/鼻づまり	Snoring/いびき
	Difficulty smelling/においが分からない		Pollen allergy/花粉症
	Something is stuck in the nose/鼻に物が入った		
Throat	Sore throat/喉が痛い	Hoarse voice/声がかれる	Oral ulcer/口内炎
	Tongue pain/舌が痛い	Cough/咳	Phlegm(mucus)/痰
	Difficulty swallowing/飲み込みにくい	Bleeding from the throat/喉から血が出る	
	Something is stuck in the throat/喉に物が引っかかっている		

Thank you

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