MIKA HAYASHI, DPM, PC
Foot & Ankle Surgery, Sports Medicine

PATIENT INFORMATION 問診表

DATE 日付: _____

患者氏名 (ローマ字) PATIENT NAME: _____ 生年月日(月/日/年) DATE OF BIRTH: ____/____/_____ 年齢 AGE: _____ 性別: SEX: _____
LAST 姓 FIRST 名 M D Y

自宅住所 HOME ADDRESS: _____ 郵便番号 ZIP: _____
CITY / STATE 市 / 州:

自宅電話 HOME PHONE : (_____)_____-_____ 会社電話 WORK PHONE : (_____)_____-_____

携帯電話 CELL PHONE : (_____)_____-_____ FAX : (_____)_____-_____

E-MAIL: _____

ご希望の連絡方法 PREFERRED METHOD OF CONTACT: 自宅電話 ☐HOME PHONE 携帯電話 ☐CELL PHONE ☐E-MAIL

配偶者の有無 MARITAL STATUS: ☐SINGLE 未婚 ☐MARRIED 既婚 ☐SEPARATED 別居 ☐DIVORCED 離婚 ☐WIDOW 死別

ご希望の言語 PREFERRED LANGUAGE: ☐ENGLISH 英語 ☐JAPANESE 日本語 ☐SPANISH スペイン語

人種 RACE: ☐ASIAN アジア人 ☐AFRICAN AMERICAN 黒人 ☐CAUCASIAN 白人 ☐AMERICAN INDIAN/ALASKAN NATIVE アメリカ先住民/アラスカ先住民
☐NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ハワイ先住民/その他太平洋諸島系 ☐OTHER その他

民族 ETHINICITY: ☐HISPANIC ORIGIN スペイン系 ☐NOT HISPANIC ORIGIN 非スペイン系

緊急連絡者 EMERGENCY CONTACT PERSON: _____ 患者との関係 RELATIONSHIP: _____ 電話番号 PHONE : (_____)_____-_____

日本での連絡先 ADDRESS IN JAPAN (IF APPLICABLE): _____

勤務先 EMPLOYER: _____ 職業 OCCUPATION: _____

主治医 PRIMARY CARE DOCTOR: _____ 電話番号 PHONE: (_____)_____-_____

最後に主治医にかかった日(月/日/年) LAST VISIT TO PRIMARY DOCTOR: _____/_____/_____
M D Y

WHERE DID YOU HEAR ABOUT US? 当院をどこでお知りになりましたか？

ネット上で検索 グーグル NYU病院のサイト 便利帳サイト ジャピオン ニューヨーク日本領事館 その他
INTERNET: ☐ GOOGLE ☐ NYU WEBSITE ☐ BENRICHO ☐ JAPION ☐ EMBASSY ☐ OTHER: _____

ご紹介 友人 他の医療機関 保険会社 その他 ご紹介頂いた方のお名前
REFERED BY: ☐ FRIEND ☐ DR'S OFFICE ☐ INSURANCE COMPANY ☐ OTHER WHO? _____

新聞・雑誌 ラジオ その他
☐ NEWSPAPER/MAGAZINE _____ ☐ RADIO ☐ OTHER _____

INSURANCE INFORMATION 保険情報

保険会社 INSURANCE COMPANY: _____ 保険 ID 番号 ID : _____

その他の保険 (あれば)
■SECONDARY (IF ANY)

保険会社 INSURANCE COMPANY: _____ 保険 ID 番号 ID : _____

CURRENT PROBLEMS 現在の症状

WHAT IS YOUR SPECIFIC PROBLEM?
現在の症状をご記入ください。

_____
_____
_____
_____
_____
_____

WHERE IS THE PAIN/ PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.
痛い部位/ 問題の部位はどこですか？下記の図に印をつけてください。

LEFT (左)

TOP (表)

BOTTOM (裏)

INSIDE (内側)

OUTSIDE (外側)

RIGHT (右)

BOTTOM (裏)

TOP (表)

OUTSIDE (外側)

INSIDE (内側)

SOCIAL HISTORY 生活歴

飲酒
■USE OF ALCOHOL: ☐NEVER 1度もない ☐NO LONGER USE やめた ☐HISTORY OF ALCOHOL ABUSE アルコール中毒の既往あり

☐DRINK 飲む –_____GLASSES 杯 / ☐EVERYDAY 毎日 ☐_____DAYS A WEEK(週のうち何日)

喫煙
■USE OF TABACCO: ☐NEVER 1度もない ☐SMOKE 喫煙する -_____CIGARETTES / DAY 本/日 FOR_____YEAR 年間

☐QUIT やめた - HOW LONG AGO? いつ？_____

HOW MANY CIGARETTES DID YOU SMOKE? どのくらい喫煙していましたか？

_____CIGARETTES / DAY 本/日 FOR_____YEAR 年間

■HOW MUCH ARE YOU ON YOUR FEET AT WORK? どのくらい立って仕事をしていますか? ☐10% ☐25% ☐50% ☐75% ☐100%

運動
■EXERCISE: ☐NEVER 全然しない ☐RARE ほとんどしない ☐OCCATIONAL 時々 ☐WEEKLY 週に1回

☐SEVERAL TIMES A WEEK 週に数回 ☐DAILY 毎日

運動の種類
TYPES OF EXERCISE: _____

身長 フィート/ センチ
■HEIGHT:_____(FEET/CM)

体重 パウンド/ キロ
■WEIGHT:_____(LBS/KG)

靴のサイズ
■SHOE SIZE: US_____

(IF APPLICABLE: 該当する方はお答え下さい)

前回の生理開始日(月/日/年)
■LAST MENSTRUAL PERIOD:_____/_____/_____
M D Y

妊娠している可能性はありますか？ はい いいえ
■POSSIBILITY OF BEING PREGNANT? ☐YES ■NO

妊娠中ですか？ はい いいえ
■ARE YOU CURRENTLY PREGNANT? ☐YES ■ NO

授乳中ですか? はい いいえ
■ARE YOU CURRENTLY NURSING? ◯YES ⊙NO

MEDICAL HISTORY 現病歴

■CURRENT MEDICATION 現在服用している薬があればご記入ください:

1. 2. 3.

4. 5. 6.

■YOUR PHARMACY INFORMATION 普段ご利用になる薬局
(NAME, PHONE NUMBER, ZIP 名前、電話番号、郵便番号)

■SURGERY HISTORY (INCLUDE DATES) 手術歴 (施術年月日もご記入ください):

1. 2. 3.

■ALLERGIES アレルギー:

■NONE なし

□TAPE テープ □LATEX ラテックス □IODINE ヨウ素 □SHELLFISH 魚貝類 □LOCAL ANESTHETICS 局所麻酔 □GENERAL ANESTHETICS 全身麻酔

□OTHER その他 (MEDICATIONS 薬剤, FOODS 食物, ENVIRONMENT 環境)

■HAVE YOU EVER HAD ANY OF THE FOLLOWING? これまでに下記の病気にかかったことがありますか？

■NONE なし

□ACID REFLUX 胃食道逆流症
□ANEMIA 貧血
□ARTHRITIS 関節炎
□ASTHMA 喘息
□BACK TROUBLE 腰痛
□BLADDER INFECTIONS 膀胱炎
□ABNORMAL BLEEDING 異常出血
□BLOOD CLOTS 血 栓 症
□BLOOD TRANSFUSION 輸血
□BRONCHITIS/EMPHYSEMA 気管支炎/肺気腫
□CANCER がん
□HIGH CHOLESTEROL 高コレステロール
□DIABETES 糖尿病
□FIBROMYALGIA 線維筋痛症
□GOUT 痛風
□HEART ATTACK 心臓発作
□HEART DISEASE/FAILURE 心臓病/心不全
□HEPATITIS 肝炎
□HIV+/AIDS HIV 陽性/エイズ
□OTHER CONDITIONS その他

□HIGH BLOOD PRESSURE 高血圧
□KIDNEY DISEASE 腎臓の病気
□LIVER DISEASE 肝臓の病気
□LOW BLOOD PRESSURE 低血圧
□MIGRAINE HEADACHS 偏頭痛
□MITRAL VALVE PROLAPSE 僧帽弁逸脱
□NEUROPATHY 神経障害
□OPEN SORES 皮膚潰瘍
□PNEUMONIA 肺炎
□POLIO ポリオ
□RHEUMATIC FEVER リウマチ熱
□SICKLE CELL DISEASE 鎌状赤血球症
□SKIN DISORDER 皮膚の病気 _____
□SLEEP APNEA 睡眠時無呼吸症候群
□STOMACH ULCERS 胃潰瘍
□STROKE 脳梗塞
□THYROID DISEASE 甲状腺の病気
□TUBERCULOSIS 結核

■DO YOU HAVE A FAMILY HISTORY OF THE FOLLOWING? 家族に次の疾患をお持ちの方はいますか?

■NONE なし

□CANCER がん who _____
□CORONARY ARTERY DISEASE 冠動脈疾患 who _____
□DIABETES 糖尿病 who _____
□HEART DISEASE 心臓病 who_____
□OTHER その他 _____

□HIGH BLOOD PRESSURE 高血圧 who _____
□RHEUMATOID ARTHRITIS リウマチ性関節炎 who _____
□STROKE 脳梗塞 who _____
□THYROID DISEASE 甲状腺の病気 who _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSINGMENT OF BENEFITS

I hereby give my permission to Dr. Mika Hayashi to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of the extremity condition.

I also hereby authorize to release any information in the course of my treatment or examination to my insurance carrier. I hereby authorize payment to Physician of Benefits due me for service rendered. I understand that I am responsible for charges not covered by this authorization.

I understand that sometimes my insurance company sends the reimbursement for the treating doctor directly to the insured. I understand that this is the payment that my insurance company will make not to the insured or myself but to the treating doctor for the service that I will receive. Thus, I agree to bring the original check(s) to your office (350 Lexington Avenue, Suite 501, New York, NY 10016) as soon as the insured or I receive them.

CANCELLATION POLICY

If a cancellation is inevitable, a courtesy notification is advised at least 24 hours in advance prior to your scheduled appointment, so that we may provide quality individualized medical care in a timely manner to other patients. Failure to notify our office in a timely manner may result in a broken appointment Fee ($50).

PRIVACY POLICY

I understand that under the Health Insurance Portability and Accountability act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct any treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly, obtain payment from third-party payers, and conduct normal health care operations such as quality assessments and physician certifications.

I have been informed by you of your Notices of Privacy containing a more complete description of the uses and disclosures of my health information. I have been given the rights to review your Notices of Privacy prior to signing this consent. I understand that Dr. Mika Hayashi, D.P.M. can change their Notices of Privacy Practices from time to time and that I can contact this office to get a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you must abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action replying on this consent.

名前 Patient's Name:	サイン Signature:	日付 Date:

未成年者の場合、保護者のサイン If minor, Guardian Signature:	患者との関係 Relationship to patient:

INFORMED CONSENT TO OBTAIN MEDICATION HISTORY

MIKA HAYASHI, DPM, PC has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your medication history. A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time to discuss everything you are taking, and for you to point out to us any errors in your medication history.

Patient Acknowledgement

By signing below, I give permission for MIKA HAYASHI, DPM, PC to obtain my medication history from my pharmacy, my health plans and other healthcare providers.

名前 Patient's Name:	サイン Signature:	日付 Date:

未成年者の場合、保護者のサイン If minor, Guardian Signature:	患者との関係 Relationship to patient: