Questionar

Fill in this box

Patient's name; ____________________ Birthday; ____________________

■Please describe in detail what is wrong with your condition. Where and how bad is it?

■When did it start?

■Please check your past illness and / or treating
□Asthma □pneumonia □Lung tuberculosis □Hyper tension
□Liver disease □Kidney disease □Diabetes □Stroke □Cancer
□Heart disease□Other disease;

■Please indicate any medicines you are currently taking.

(ID)

Address : 〒

Phone number :

Contact name : Phone number :

Home doctor : Phone number :

Rehabilitation Plus