Please tick the relevant box!

☐First time visitor　☐For those who have not visited our clinic for a long time

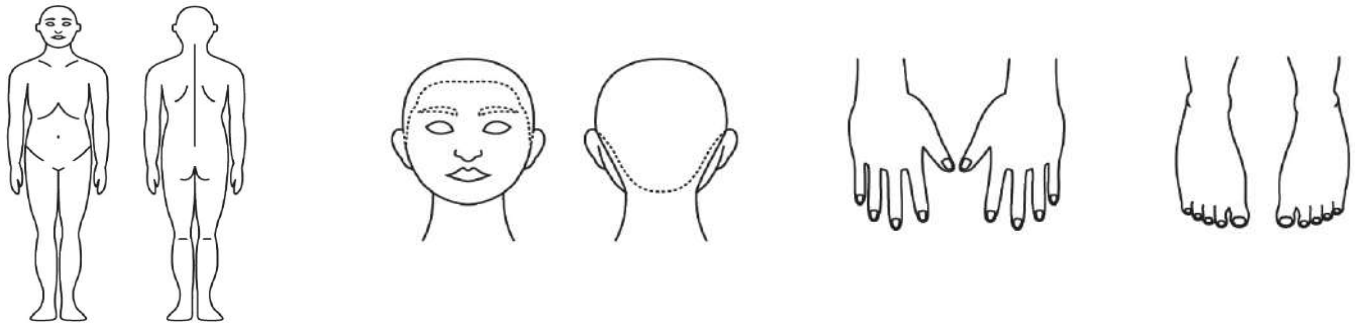
NAME	/　/	
	(Family name)　(First name)　(Middle name)	
ADDRESS	〒　－	
TEL		☐ Female　☐ Male
DATE of BIRTH	/　/ Year(年)/Month(月)/Day(日)	Age:　years old
Height/weight	cm　kg	Occupation：

1. What are your main concerns?

☐Rash（発疹）☐Itchy（かゆい）☐Painful（痛い）☐Burn（火傷）☐Wart（いぼ）
☐Athlete's foot/ fungal infection（水虫）☐Acne（にきび）☐Acne scar（にきび痕）
☐Hair loss/alopecia（脱毛）☐Pigmentation（色素沈着）☐Mole/nevus（ほくろ）
☐Armpit odor, hyperhidrosis（わきが・多汗症）☐Wrinkle（しわ）
☐Menopause symptom（更年期障害）☐Other（その他）:

＊If you wear make-up or sunscreen on the symptomatic area, please remove it before the examination.

2. Mark the location of the lesion or problem areas.



3. When did the symptoms first appear?

(Year)　/　(Month) /　(Day)

4. Are you currently pregnant or nursing? (For women only).

☐Yes: Pregnant (　months)　☐Yes: Nursing
☐No

5. Do you have any allergies to any drugs?

☐Yes: Name of drug(　)
☐No

6. Do you have any allergies except for medicines?

☐Yes: e.g. Metals, Food, Animals, Pollen, Other (　)
☐No

↓Please continue on the reverse side.↓

7. In your opinion, what could be the cause of the issues?

(　　)

8. Have you been treated for this symptom at another medical institution?

☐Yes → Hospital name (　　)

Details of treatment & Name of drug

(　　)

☐No

9. Have you ever had or are you currently being treated for any illnesses?

☐Yes→ High blood pressure(高血圧)/ Hyperlipidaemia（高脂血症）/
Diabetes（糖尿病）/ Gout（痛風）/Angina pectoris（狭心症）/
Myocardial infarction（心筋梗塞）/ Stroke（脳卒中）/ Asthma（喘息）/
Glaucoma（緑内障）/ Other (　　)

☐No

10. Are you currently taking any medicines, over-the-counter drugs, or supplements?

☐Yes → Name of drug (　　)

☐No

11. Do you drink alcohol?

☐Yes → Daily / Occasionally

☐No

12. Do you smoke cigarettes?

☐Yes → Number of cigarettes smoked per day (　　cigarettes)

☐No

13. We also offer the following cosmetic treatments. Please tick the items you are interested in.

☐Whitening/facial whitening (・oral drug treatment ・topical drug treatment ・laser treatment)☐Placenta injections ☐Beautiful skin and cosmetic injections ☐Beautiful skin and cosmetic drip ☐Hyaluronic acid injections ☐ Botulinum injections ☐ Eyelash growth products ☐ Medical laser hair removal

14. How did you know our clinic?

☐You had already been to our clinic ☐A local information magazine (Cooter)
☐Pamphlet of our clinic ☐Referral from a family ☐Referral from an acquaintance
☐Homepage of our clinic by internet search
☐Homepage of our clinic by internet advertisement
☐Website: (Doctor's File) ☐Website: (Hospital Navi) ☐Website : (caloo)
☐Website : (Medical DOC) ☐Facebook ☐Instagram ☐LINE
☐Signboard ☐Telephone book ☐Tsuchiura city window envelope
☐Other（　　）
☐Referral from other medical institutions

***Thank you for filling out this form.**