



Oak Clinic Men's Preliminary Screening Form

名前 Name	Phone () Mobile ()	—	身長 Height	cm	体重 Weight	kg
国籍 Nationality	住所 Address					
生年月日 Date of birth	_____year _____month _____day	年齢 Age	職業 Occupation			

- ・ At Oak Clinic, in accordance with the law regarding the protection of personal information, every patients personal information is confidential and patients privacy is protected.
- ・ Please understand that at times when it is necessary we will call you on the telephone/mobile phone number that you have provided us with.

Have you ever had the mumps? おたふくかぜにかかったことがありますか？

1. No 2. Not sure 3. Yes (age:)
 (At that time, testicles had: 1. Swollen 2. Not swollen 3. Not sure) (そのとき睾丸が 1. はれた 2. はれない 3. わからない)

Have you ever had surgery on your testicles or vas deferens? 睾丸や精管の手術を受けたことがありますか？

1. No 2. Not sure 3. Yes (age:)

Have you ever had surgery for a hernia (groin hernia)? 脱腸(鼠径ヘルニア)の手術を受けたことがありますか？

1. No 2. Not sure 3. Yes (age:)

Have you ever had urethritis, epididymitis, or prostatitis? 尿道炎,副睾丸炎,前立腺炎にかかったことがありますか？

1. No 2. Not sure 3. Yes (age:)

Have you ever had a wound or burn to the penis or the testicles? 陰茎,睾丸など外陰部に外傷,火傷をしたことがありますか？

1. No 2. Not sure 3. Yes (age:)

Have you ever had purulent accumulation, bronchiectasis, or chronic bronchitis? 蓄膿,気管支拡張症,慢性気管支炎にかかったことがありますか？

1. No 2. Not sure 3. Yes (age:)

Have you ever had radiation treatment? 放射線治療を受けたことがありますか？

1. No 2. Not sure 3. Yes (age:) (Disease name:)

Have you ever had anti-cancer drug treatment? 抗癌剤治療を受けたことがありますか？

1. No 2. Not sure 3. Yes (age:) (Disease name:)

Are you presently being treated for a disease such as diabetes? 糖尿病など、過去または現在治療中の病気がありますか？

1. No 2. Not sure 3. Yes (age:) (Disease name:)

In the past 3 months, have you had a high fever or poor health conditions? 最近3ヶ月間に高熱や体調不良がありましたか？

1. No 2. Yes (Disease name:)

Are there any medicines you are taking on a regular basis? 常用薬剤がありますか？

1. No 2. Yes (Medicine name:)

Are you a smoker? タバコは吸いますか？

1. No 2. Yes (_____cigarettes/day from age _____) 吸う(_____歳から一日 _____本)

Do you drink alcohol? アルコールは飲みますか？

1. No 2. Yes (A lot · Average · A little) (多量 · 普通 · 少し)

Do you shave everyday? ひげは毎日剃りますか？

1. Yes 2. Hardly ever ほぼ剃らない 3. Sometimes (Once every _____ days) ときどき (_____日に一度)

Is there a problem with your erection? 勃起に問題がありますか？

1. No 2. Not sure 3. Yes

Is there a problem with your ejaculation? 射精に問題がありますか？

1. No 2 Not sure 3 Yes

Do you have any allergies to medicine or food? 薬や食べ物にアレルギーがありますか？

1. No 2. Not sure 3. Yes ()

Have you ever had asthma? ぜんそくにかかったことがありますか？

1. No 2. Not sure 3. Yes

Have you ever had a blood transfusion? 輸血をうけたことがありますか？

1. No 2. Not sure 3. Yes (Blood type _____ Rh (+ / -))

妻の名前 Wife's Name	年齢 Age	職業 Occupation	血液型 Blood type() Rh (+ / -)
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We do have an available interpretation service for a fee. If you wish to have an interpreter available, please ask the staff.