Pediatric Medical Questionnaire

Child' s Name (in Hiragana)	M ・ F	Age _____years _____months	Weight kg	Temp. at Visit ℃

※ Please submit any documents requiring the doctor's signature to the reception desk in advance.

1. Current Symptoms

Please circle your current symptoms and complete the corresponding sections.

For follow-up visits, please indicate any changes since your last visit.

Symptoms	Date begin(MM/DD)	Severity / Details	Changes since last visit
Fever	／ Time____	Highest temp._____℃	□ Back to normal temperature □ Fever persists
Cough	／	□ Mild □ Severe	□Improved □Unchanged □ Worsened
Runny or stuffy nose	／	□ Mild □ Severe	□Improved □Unchanged □ Worsened
Sore throat	／	□ Mild □ Severe	□ Resolved □ Unchanged □ Worsened
Vomiting	／	Number of episodes: ____	□ Resolved □ Unchanged □ Increased
Nausea	／	□ Mild □ Severe	□ Resolved □ Unchanged □ Worsened
Diarrhea	／	____times/day Loose/ Watery	□ Resolved □ Unchanged □ Increased
Abdominal pain	／	□ Occasional □ Constant	□ Resolved □ Still present
Headache	／	□ Occasional □ Constant	□ Resolved □ Still present
Rash	／	Location : _____ Itching : □ Yes □ No	□ Improved □ Unchanged □ Worsened

2. Condition at Home

Appetite : □ Normal □ Less than usual □ Almost no food intake

Fluid intake : □ Normal □ Less than usual □ Almost no fluid intake

Urine output : □ Normal □ Less than usual □ Much less than usual

Mood and activity level : □ Normal □ Slightly reduced □ Significantly reduced

3. Have you visited another medical facility for these symptoms?

No / Yes → Date: ___ / ___ Medication: _____

If prescribed, please show us the prescription record book.

4. Attending daycare, preschool, or school?

No / Yes → Name: _____ □ Daycare □ Preschool □ School

5. Any infectious diseases spreading nearby?

No / Yes → Where? _____ Disease: _____

6. Any allergies to medicine?

No / Yes → Medication: _____

7. Currently taking any medication prescribed elsewhere?

No / Yes → Illness: _____ Medication: _____

8. Any history of seizures?

No / Yes → Most recent: _____ Year _____ Month / Age: _____ years

9. Other concerns or requests: (e.g. checkup, medication refill, test results)

_____

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