THINK PARK TOWER INTERNATIONAL CLINIC

Name: ☐ Male ☐ Female

Occupation: Date of Birth: Age:

1. What are your symptoms? When did it start?

Symptoms:

☐ Fever	☐ Cough	☐ Rash
☐ Dizziness	☐ Stomachache	☐ Chest pain
☐ Headache	☐ Sore throat	☐ Diarrhea
☐ Nausea	☐ Vomiting	☐ Palpitation
☐ Abdominal pain	☐ Shortness of breath	

☐ Others ( )

2. Have you or any of your family members ever had the following disease?

☐ Stroke	( )	☐ Heart disease	( )
☐ Diabetes mellitus	( )	☐ Hepatitis	( )
☐ Kidney disease	( )	☐ Hyperlipidemia	( )
☐ Gout	( )	☐ Cancer	( )

☐ Others ( )

3. Have you ever had an allergic reaction to a medicine(s) or food? If so, please specify.

☐ Yes ( ) ☐ No

4. Questions for women

Last menstrual period: Month( ) Date( ) Year( )

Are you pregnant or do you have a possibility of pregnancy?

☐ Yes(Months) ☐ No

5. Do you have any questions for the doctor?

Thank you for your cooperation.