covid19 vaccine aplication（Please fill in the reverse side as well.）

NAME _____

BIRTHDAY _____ **Y.O** _____ **YEAR** _____ **MONTH** _____ **DAY** _____

ADDRESS _____

mobile phone number _____

emergency contact ＜**who** ＞ _____

Do you go to hospital regularly？ ☐ YES ☐ NO	If "yes," what is the name of the medical institution and the name of the disease?
Are there any medications you are currently taking? ☐ YES ☐ NO	If "yes," what is the name of the medicne ?
Do you have a medical history? ☐ YES ☐ NO	If yes, please tell us when and what kind of illness you had.

Do you have any allergies to medicines or food?

< >

Have you ever had a rash from alcohol disinfection?

□YES □NO

Which hand is your dominant?

□RIGHT □LEFT

Do you smoke?

□ NO

□ YES（how many /day× years）

Do you drink?

□ NO

□ YES （ day/week, ml/day）

How did you find out about us?	□ 1 Referral from an acquaintance who _____さま □ 2 Referrals from other medical institutions □ 3 passing (along the way) □ 4 Home Page

*Thank you for your cooperation.