

## Talatanungan sa Saykaytrya/Psychiatry Questionnaire/精神科 問診票

Pangalan ng pasyente/Name of patient /患者氏名			BT= _____ °C PR= _____ min./min./分 BP= _____ mmHg RR= _____ /mmHg SPO2= _____ %
Araw ng kapanganakan /Date of birth /生年月日 (西暦)	Taon /Year/年 Buwan /Month/月 Araw /Day/日 ( Taong gulang/Years old/歳 )	Para sa mga tauhan lamang /For staff only /医療機関記入欄	
Taas/Timbang/Height/Weight/身長・体重	_____ cm/cm      kg/kg	kasarian/Sex/性別	<input type="checkbox"/> Lalaki/Male/男性 <input type="checkbox"/> Female/Female/女性
Mga allergy/Allergies /アレルギーの有無	<input type="checkbox"/> (mga) pagkain/Food(s)/食べ物: <input type="checkbox"/> Medicine/Medicine/薬:		

**Ano ang problema ngayon? (Lagyan ng tsek ang lahat ng naaangkop.)/What is the problem today?(Check all that apply.)**  
 /今日はどのような症状がありますか。(複数ある方は複数回してください。)

- |   |  |  |  |   |   |
|---|--|--|--|---|---|
| <input type="checkbox"/> Hindi makatulog<br>/Insomnia/不眠  | <input type="checkbox"/> Pagkabalisa<br>/Anxiety/不安  | <input type="checkbox"/> Kinakabahan/Nervous<br>us/緊張する  | <input type="checkbox"/> Nalulumbay<br>/Feel depressed<br>/気分が滅入る            | <input type="checkbox"/> Mababang enerhiya<br>/Low energy<br>/やる気が出ない         | <input type="checkbox"/> Mababang konsentrasyon<br>/Lowered concentration<br>/集中力低下                 |
| <input type="checkbox"/> Problema sa pamilya<br>/Problem with family<br>/家庭の悩み  | <input type="checkbox"/> Problema sa trabaho<br>/Problem at work<br>/職場の悩み                   | <input type="checkbox"/> Problema sa paaralan<br>/Problem with school<br>/学校の悩み                | <input type="checkbox"/> Abnormal na gana<br>/Abnormal appetite<br>/食欲異常     | <input type="checkbox"/> Takot sa ibang tao<br>/Fear of other people<br>/人が怖い | <input type="checkbox"/> Pagdingig sa guni-guni<br>/Auditory hallucination<br>/幻聴・幻覚                |
| <input type="checkbox"/> Palpitasyon<br>/Palpitation/動悸   | <input type="checkbox"/> May mga pisikal na sintomas<br>/Have physical symptoms<br>/身体の症状がある | <input type="checkbox"/> Parang gusto ko ng mamatay.<br>/I feel like I want to die.<br>/死にたくなる | <input type="checkbox"/> Hirap sa paghinga<br>/Difficulty breathing<br>/息苦しさ | <input type="checkbox"/> Pawis sa kamay<br>/Sweat in the hands<br>/手に汗をかく     | <input type="checkbox"/> Kusang gumagalaw ang katawan<br>/The body moves spontaneously<br>/身体が勝手に動く |
| <input type="checkbox"/> Pagbawas ng timbang<br>/Lose weight<br>/体重が減る  | <input type="checkbox"/> Hindi maigalaw ang katawan<br>/Cannot move the body<br>/身体がうごかない    |  |  |   |   |
| <input type="checkbox"/> Ako ay pinayuhan ng isa pang klinika/ospital (o sa isang regular na check-up) na pumunta dito.<br>/I was advised by another clinic/hospital (or at a regular check-up) to come here./他の医療機関から受診するように勧められた (健診含む) |  |  |  |   |   |
| <input type="checkbox"/> Iba pang (mga)/Other(s)<br>/その他:   |  |  |  |   |   |

**Ano ang sintomas?/What is the symptom like?**  
 /症状はどのような性質を持っていますか。

- |  |  |
|--|--|
| <input type="checkbox"/> pare-pareho/Constant/絶え間なく、続いている  | <input type="checkbox"/> Ang sintomas ay unti-unting lumalala./The symptom is gradually worsening.<br>/徐々にひどくなってきている |
| <input type="checkbox"/> Dumarating at nawawala ang sintomas./The symptom comes and goes.<br>/症状が出たり消えたりしている | <input type="checkbox"/> Iba pa/Other(s)<br>/その他:  |

**Kailan nagsimula ang sintomas?/When did the symptom start?**  
 /この症状はいつからありますか。

\_\_\_\_\_ Taon /Year \_\_\_\_\_ Buwan /Month \_\_\_\_\_ Araw /Day \_\_\_\_\_ Mula sa/From about \_\_\_\_\_ : \_\_\_\_\_ am/am/pm/pm  
 午前・午後 時 分ごろから

**Bumubuti ba ang iyong sintomas?/Is your symptom improving?**  
 /現在、その症状はよくなっていますか。

- |   |   |
|---|---|
| <input type="checkbox"/> Bumubuti na ang sintomas./The symptom is getting better.<br>/よくなっている | <input type="checkbox"/> Lumalala ang sintomas./The symptom is getting worse.<br>/悪くなってきている |
|---|---|

**Kasalukuyan ka bang umiinom ng anumang gamot, kabilang ang bitamina at nutritional supplement?**  
 /Are you currently on any medication, including vitamin and nutritional supplement?  
 /現在、飲んでいる薬はありますか? ※ビタミン、栄養剤、サプリメントも含まれます。

- Hindi/No /いいえ     Oo/Yes /はい  
 \*Ipakita sa amin ang iyong talaan ng gamot o gamot (notebook).  
 /Show us your medication or medication record (notebook).  
 /お薬、もしくは「お薬手帳」を持っている方は、見せてください。

	Pangalan ng mga gamot /Name of medications /お薬の名前	Paano inumin o gamitin ang iyong gamot /How to take or use your medication /飲み方・使い方		Pangalan ng mga gamot /Name of medications /お薬の名前	Paano inumin o gamitin ang iyong gamot /How to take or use your medication /飲み方・使い方
①			⑥		
②			⑦		
③			⑧		
④			⑨		
⑤			⑩		

ikaw ba ay nasa ilalim ng or sumailalim sa pangangalaga ng isang doktor?/Are you, or have you been, under the care of a doctor in the past?  
 /現在治療している病気、または過去に治療していたことはありますか?

Hindi/No /いいえ  Oo/Yes /はい

Kung nilagyan mo ng check ang "Oo", piliin ang kundisyon mula sa listahan, at isulat ang pangalan ng ospital kung saan ka tumanggap ng paggamot.  
 /If you checked "Yes", choose the condition from the list, and write the name of the hospital where you received treatment.  
 /「はい」に印した人は、疾患名リストから選択し、治療していた医療機関名を書いてください。

Pangalan ng sakit (Isulat ang numero mula sa sumusunod na listahan) /Name of disease (Write the number from the following list) /疾患名 (下記リスト番号可)	Pag-unlad ng paggamot/Treatment progress /治療経過	Pangalan ng ospital/Hospital name /医療機関名
	<input type="checkbox"/> Gumaling/Recovered/治療 <input type="checkbox"/> Kasalukuyang ginagamot/Under treatment/現在治療中 <input type="checkbox"/> Itinigil ang paggamot/Withdrawal of treatment/治療中断 <input type="checkbox"/> Hindi ginagamot/Untreated/未治療	
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<Listahan ng mga sakit/List of diseases/疾患リスト>

Sistema ng sakit/System of disease /疾患の系統	Mga pangalan ng sakit/Disease names /疾患名
① Sakit sa pagtunaw /Digestive disease /消化器系の疾患	a. Peptic ulcer/Peptic ulcer /消化器潰瘍 b. Hepatitis/Hepatitis /肝炎 c. Hepatic cirrhosis /Hepatic cirrhosis /肝硬変 d. Iba pa/Others/その他
② Sakit sa sistema ng sirkulasyon/Circulatory system disease /循環器系の疾患	a. Alta-presyon/Hypertension /高血圧 b. Angina pectoris /Atake sa puso /Angina pectoris /myocardial infarction /狭心症・心筋梗塞 c. Arrhythmia/Arrhythmia /不整脈 d. Heart failure /Heart failure/心不全 e. Iba pa/Others/その他
③ Sakit sa paghinga /Respiratory disease /呼吸器系の疾患	a. Hika/Asthma/喘息 b. Chronic obstructive pulmonary disease /Chronic obstructive pulmonary disease /慢性閉塞性肺疾患 c. Pulmonya/Pneumonia /肺炎 d. Tuberculosis sa baga/Pulmonary tuberculosis /肺結核 e. Iba pa/Others/その他
④ Sakit sa bato at urological/Kidney and urological disease /腎・泌尿器系の疾患	a. Talamak na pagkabigo sa bato /Chronic renal failure /慢性腎不全 b. Bato/Bato sa ihi /Renal/urinary stone /腎・尿管結石 c. Impeksyon sa ihi /Urinary tract infection /尿路感染症 d. Iba pa/Others/その他
⑤ Sakit sa utak at nervous system/Brain and nervous system disease /脳神経系の疾患	a. Cerebral infarction /Cerebral infarction /脳梗塞 b. Pagdurugo ng tsebral/Cerebral hemorrhage /脳出血 c. Epilepsy/Epilepsy /てんかん d. Iba pa/Others/その他
⑥ Endocrine o metabolic disease/Endocrine or metabolic disease /内分泌代謝系の疾患	a. Diabetes mellitus/Diabetes mellitus /糖尿病 b. Hyperlipidemia/Hyperlipidemia /高脂血症 c. Maling paggana ng thyroid gland /Thyroid gland malfunction /甲状腺機能障害 d. Hyperuricemia/Hyperuricemia /高尿酸血症 e. Iba pa/Others/その他
⑦ Sakit sa buto o kalamnan/Bone or muscle disease /骨・筋肉の疾患	a. Rheumatoid arthritis/Rheumatoid arthritis /関節リウマチ b. Osteoporosis/Osteoporosis /骨粗鬆症 c. Osteoarthritis/Osteoarthritis /変形性関節症 d. Herniated intervertebral discs /Herniated intervertebral discs /椎間板ヘルニア e. Gout/Gout/痛風 f. Iba pa/Others/その他
⑧ Sakit sa Obstetrics at ginekolojiya/Obstetrics and gynecology disease /産婦人科の疾患	a. May isang ina fibroids /Uterine fibroids /子宮筋腫 b. Dysmenorrhea /Dysmenorrhea /月経困難症 c. kawalan ng katabaan /Infertility/不妊症 d. Iba pa/Others/その他
⑨ Sakit sa mata/Eye disease /眼の疾患	a. Katarata/Cataract /白内障 b. Glaucoma/Glaucoma /緑内障 c. Retinopathy /Retinopathy/網膜症 d. Iba pa/Others/その他
⑩ Malignant na tumor/Malignant tumor /悪性腫瘍	a. Kanser sa tiyan /Stomach cancer/胃癌 b. Kanser sa bituka/Colon cancer/大腸がん c. Atay/gallbladder/pancreatic cancer /Liver/gallbladder/pancreatic cancer /肝臓・胆のう・膵臓がん d. Cancer sa suso/Breast cancer/乳がん e. Kanser sa matris /Uterine cancer /子宮がん f. Kanser sa baga /Lung cancer/肺癌 g. Iba pa/Others/その他
⑪ Sakit sa utak/Mental disease /精神の疾患	a. Depresyon/Depression /うつ病 b. Schizophrenia/Schizophrenia /統合失調症 c. Iba pa/Others/その他
⑫ sakit sa ENT /ENT disease /耳鼻科の疾患	a. May kapansanan sa pandinig/Impaired hearing /難聴 b. Pagkahilo/Dizziness /めまい c. Ingay sa tenga /Ear noise/耳鳴 d. Allergy sa pollen /Pollen allergy/花粉症 e. Iba pa/Others/その他
⑬ Sakit sa dugo /Blood disease /血液の疾患	a. Anemia/Anemia/貧血 b. Leukemia/Leukemia /白血病 c. Iba pa/Others/その他
⑭ Sakit sa balat /Skin disease /皮膚の疾患	a. Atopic dermatitis/Atopic dermatitis /アトピー性皮膚炎 b. Alipunga (athlete's foot) /Tinea (athlete's foot) /白癬症 (水虫) c. Iba pa/Others/その他

**Naoperahan ka na ba?/Have you ever had surgery?**  
**/今までに手術をしたことがありますか。**

- Hindi/No /いいえ     Oo/Yes /はい

Kung nilagyan mo ng check ang "Oo", isulat ang kasaysayan ng iyong operasyon.  
 /If you checked "Yes", write the history of your surgery.  
 /「はい」に印した方は下に手術歴を書いてください。

Mga pangalan ng sakit/Disease names /疾患名	Pangalan ng iyong operasyon /Name of your surgery/手術名	Kailan ka naoperahan /When you had the surgery /手術をした時期	Ospital kung saan ka nagkaroon ng operasyon /Hospital where you had the surgery

\*Kung hindi ka sigurado tungkol sa eksaktong petsa ng operasyon, isulat ang taon o edad.  
 /If you are not sure about the exact date of the surgery, write the year or age.  
 /※詳しい手術日がわからない場合は「年齢」、「手術した年」でも構いません。

**Regular ka bang naninigarilyo?/Do you smoke regularly?**  
**/習慣的に、たばこを吸いますか。**

- Hindi/No /いいえ     Oo/Yes /はい     Dating naninigarilyo/Used to smoke /以前吸っていた

Pagkonsumo ng sigarilyo /Cigarette consumption/喫煙量	Tagal ng paninigarilyo/Duration of smoking /喫煙期間	Taon kung kailan ka tumigil sa paninigarilyo /Year when you stopped smoking /喫煙をやめた年
_____ sigarilyo/Araw /cigarettes/Day /本/日	_____ taon/Year/年	_____ taon/Year/年 _____ buwan/Month/月

\*Kung mayroon ka pa ring ugali sa paninigarilyo, iwang blangko ang tanong tungkol sa taon na huminto ka sa paninigarilyo./If you still have a smoking habit, leave a blank in the question about the year you stopped smoking.  
 /現在も喫煙を続けている方は、喫煙をやめた年は空欄のままにしておいてください。

**Palagi ka bang umiinom?/Do you drink regularly?**  
**/習慣的にお酒を飲みますか。**

- Hindi/No /いいえ     Oo/Yes /はい     Dating umiinom/Used to drink regularly /以前飲酒する習慣があった。

<input type="checkbox"/> Beer/Beer/ビール _____ ml /Araw/ml /Day/日	<input type="checkbox"/> Whisky/Whisky /ウイスキー _____ ml /Araw/ml /Day/日
<input type="checkbox"/> Japanese sake /Japanese sake/日本酒 _____ ml /Araw/ml /Day/日	<input type="checkbox"/> alak/Wine/ワイン _____ ml /Araw/ml /Day/日
<input type="checkbox"/> Iba pa/Other(s)/その他 _____ ml /Araw/ml /Day/日	

**Kung babae, sagutin ang mga tanong sa ibaba. Buntis ka ba, o posibleng buntis ka?/If female, answer the questions below. Are you pregnant, or possibly pregnant?**

- Hindi/No /いいえ     Oo/Yes /はい     Hindi alam/Do not know/わからない

**nagpapasuso ka ba?/Are you breastfeeding?**  
**/現在、授乳中ですか。**

- Hindi/No /いいえ     Oo/Yes /はい

**Kung mayroon kang espesyal na kahilingan tungkol sa konsultasyon, lagyan ng check ang kahon.**  
**/If you have a special request concerning the consultation, check the box.**  
**/診察でのご希望がある場合は、☑をしてください。**

- Gusto kong malaman nang maaga ang aking tinantyang gastos sa pagpapagamot./I want to be informed of my estimated medical expenses in advance. /あらかじめ、医療費の概算を教えてください。
- Gusto kong magkaroon ng interpreter kung may available na serbisyo ng interpreter /I want to have an interpreter if an interpreter service is available./通訳がある場合は、通訳を付けてほしい。
- Iba pa/Other(s)/その他 :

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