PIONEER DIAGNOSTIC CENTER PLC

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Patient Registration Form
የታካሚ መሙያ ቅፅ

Order No. _____

ሥም / Name _____

እድሜ /Age _____
ፆታ/ Sex _____
ክብደት / Weight _____
የደረሱበት ጊዜ / Time of Arrival _____
የቀጠሮ ሰዓት/ Appointment Time _____
Walk in / Emergency _____

ለቢሮ ስራ ብቻ / For Office Use Only

Clinical Symptoms

_____
_____
_____
_____

Duration_____

Previous Radiological Examination

_____

ለጥንቃቄ እንዲረዳ ከዚህ በታች ለሚጠየቁት ጥያቄ መልስ ይስጡ ።።
For safety reason, please answer Yes or No and indicate if you have any of the following:

	አዎ YES	**የለም** NO
1. **ለደም ግፊት/ ስኪር የሚወስዱት መድሃኒት አለ?** Do you take a blood pressure /diabetic Drug?	☐	☐
2. **ለመድሃኒት አለርጂ ኖት** Are you Allergic to Drug?	☐	☐
3. **አስም አሎት** ? Do you have Asthma?	☐	☐
4. **ለመድሃኒት ለተወሰኑ ምግቦች ወይንም ለኬሚካሎች አለርጂ ኖት?** Are you allergic to drug, food or chemical substance or other?	☐	☐
5. **የኩላሊት ህመም አለብዎት ?** Do you have a kidney problem?	☐	☐
6. **የመተንፈስ ችግር አለብዎት ?** Do you have breathing problem or motion?	☐	☐
7. **ከዚህ በፊት የቀዶ ጥገና ህክምና አድርገው ያውቃሉ ?** Have you undergone any type of surgery?	☐	☐
ለሴቶች ብቻ /Only for Women		
8. **አሁን ጡት ያጠባሉ** ? Are you currently breastfeeding?	☐	☐
9. **እርግዝና አለዎት ወይንም አርግዣለሁ ብለው ይጠረጥራሉ ?** Are you pregnant or suspect you might be pregnant?	☐	☐

የታካሚውን መጠየቂያ ፎርም የሞላችዉ/ዉ ባላሞያ ስም
Name of the Nurse that filled the patient form

_____

ፊርማ _____ **ቀን** _____
Signature Date

የታካሚው ወይም የወላጅ ፊርማ
Signature of patient (Davent)

_____

ስልክ / Telephone _____

ፓዮኒርን ስለመረጡ አናመሰግናለን !

Thank you for Choosing Pioneer!