受付票 兼 同意書（REGISTRATION and AGREEMENT Form）

臨床研究等情報利用ご協力のお願い

医療法人 CVIC では、心臓特化型画像センターを中心に、心血管病を中心とした、診断精度、画像診断技術向上のための臨床研究・共同開発等を継続的に実施しております。当法人にて撮影した画像及び付随する臨床情報等は、個人を特定出来ない形で匿名化などを行い、医療技術の進歩に結びつく研究・機器開発目的等に利用させて頂きます。ご理解とご協力をお願いいたします。

INFORMED CONSENT FOR CLINICAL STUDIES

As a cardiovascular specialized imaging center, Cardiovascular Imaging Clinic（CVIC）group is constantly striving to improve diagnostic performance and those technologies by conducting multiple clinical studies. We use your images and clinical data anonymously（unknown by name）for clinical studies and software and device development. Please agree with the participation in studies for the prevention of cardiovascular disease.

医療法人社団 CVIC 理事長（Chairman of CVIC Medical Corporation）
寺島正浩（Masahiro Terashima）MD, PhD, FACC

CVIC
Cardiovascular Imaging Clinic

医療法人社団 CVIC
東京都新宿区新小川町 1-14 飯田橋リーブレックスビズ 4F

CVIC ID：

フリガナ			
Name 名前	様　（ MALE 男 ・ FEMALE 女 ）		
Date of Birth 生年月日	大正・昭和・平成　　年（西暦　　YYYY 年）　MM 月　DD 日（　　Age 歳）		
Zip code 郵便番号			
Address 住所			
Cell Phone 電話（携帯）		Phone Home 電話（自宅）	
E-mail メールアドレス			
Visiting History 来院履歴	First Visit 初診（初めての方）　・　Revisit 再診（2 回目以降の方）		

上記内容に同意します。（I agree with INFORMED CONSENT FOR CLINICAL STUDIES of CVIC.）

Your own Signature 受診者署名（本人自署）：　　Date 日付：

―上記受診者の代理署名として（per procurationem for above person or patient）―

p.p. Print Name 代諾者氏名（氏 名）：　　Relationship/Company name etc. 続柄／所属：

p.p. Signature 代諾者署名（代諾者署名）：　　Date 日付：

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CVIC Patient Questionnaire

CVIC ID :

Name		Gender	Male | Female
Date of Birth(DOB)	Year month day / /	Occupation	

1 Have any relatives had heart disease? 〔 Yes | No 〕
〔 Grandfather | Grandmother | Father | Mother | Brother | Sister 〕
Have any relatives died suddenly? 〔 Yes | No 〕

2 Have you ever been told that you have the following conditions?
〔 High blood pressure | High cholesterol | High triglycerides | Diabetes 〕
Are you taking medication for any of the above conditions? 〔 Yes | No 〕

3 Have you been diagnosed with any of the following diseases? 〔 Yes | No 〕
〔 Heart attack | Angina | Irregular heartbeat | Valvular disease | Congenital disorder |
Pulmonary embolism | Deep vein thrombosis | Brain disease | Kidney disease | Glaucoma |
Asthma (☐Current | ☐Childhood only) 〕

4 Have you undergone any heart surgery or procedures? 〔 Yes | No 〕
〔 Cardiac catheterization | Prosthetic valves | Pacemaker insertion | Stent treatment |
Aneurysm of aorta | Arrhythmia | Other : 〕

5 Do you have a history of allergic reactions? 〔 Yes | No 〕
〔 Pollen | Medication | Food | Other: 〕

6 Do you smoke? 〔 Yes | No 〕
〔 If yes, how many cigarettes per day? ____ | If you quit, how many years ago did you quit
and how many cigarettes did you smoke per day? ____ 〕

7 Do you consume alcohol? 〔 Everyday | Sometimes: mL/day | No 〕

8 Do you exercise regularly? 〔 Yes | No 〕
〔If yes, what type of exercise? : _____ Frequency :____times per month / week / day〕

9 Do you have claustrophobia (fear of enclosed spaces)? 〔 Yes | No 〕
Do you have any metals in your body? 〔 Yes | No 〕
〔 Implant | False tooth | Stent | Other : 〕

10 Do you experience chest pain, tightness, or difficulty breathing? 〔 Yes | No 〕
If yes, please provide more details Onset: _____
・Frequency: 〔 ____ times per month / week / day 〕
・Severity: 〔 Mild | Moderate | Severe 〕
・Description: 〔 Pressure | Heaviness | Tightness | Tingling | Pounding | Prickling 〕
・Time of occurrence: 〔 Early morning | Morning | Afternoon | Midnight | Anytime 〕
・When does it occur: 〔 During exercise | During rest | Both 〕
・Is it worsening recently? 〔 Yes | No 〕
Do you experience any of the following symptoms? 〔 Yes | No 〕
〔Pain in left shoulder | Pain in left arm | Chin/teeth ache | Cold sweat | Muscle weakness 〕

11 Sleep.
Usual bedtime : _____ Usual wake-up time : _____
Quality of sleep : 〔 Good | Average | Poor 〕

12 * For females: Have you gone through menopause? 〔 Yes | No 〕
Are you currently pregnant? 〔 Yes | No 〕

13 Other concerns or worries :