

健康診断書

CERTIFICATE OF HEALTH (to be completed by the examining physician)

日本語又は英語により明瞭に記載すること。

Please fill out (PRINT/TYPE) in Japanese or English. Do not leave any items blank.

氏名 Name: _____
Family name, First name Middle name

男 Male 生年月日 Date of Birth: _____ 年齢 Age: _____
女 Female

1. 身体検査 Physical Examinations

(1) 身長 Height _____ cm 体重 Weight _____ kg

(2) 血圧 Blood pressure _____ mm/Hg ~ _____ mm/Hg 血液型 Blood Type

A B O	RH	+
		-

脈拍数 Pulse Rate _____ /min 整 regular
不整 irregular

(3) 視力 Eyesight: (R) _____ (L) _____ (R) _____ (L) _____
裸眼 without glasses 矯正 with glasses or contact lenses

(4) 聴力 Hearing: 正常 normal 言語 speech: 正常 normal
低下 impaired 異常 impaired

2. 申請者の胸部について、聴診とX線検査の結果を記入してください。X線検査の日付も記入すること (6ヶ月以上前の検査は無効。)
Please describe the results of physical and X-ray examinations of applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).



肺 lung: 正常 normal 異常 impaired

Date _____

Film No. _____

Describe the condition of applicant's lung.

心臓 Cardiomegaly: 正常 normal 異常 impaired

心電図 Electrocardiograph
正常 normal 異常 impaired

3. 現在治療中の病気 Disease & Treatment at Present Yes (Disease: _____ Medicine: _____)
No

4. 既往症 Past history: Please indicate with + or - and fill in the date of recovery.

Tuberculosis..... (. . .) Malaria..... (. . .) Measles..... (. . .)
Epilepsy..... (. . .) Kidney disease..... (. . .) Heart diseases..... (. . .)
Diabetes..... (. . .) Drug allergy..... (. . .) Psychosis..... (. . .)
Functional disorder in extremities..... (. . .) Others..... (. . .)
Rheumatic fever..... (. . .) Hepatitis..... (Type: A, B, C, D, E) (. . .)

5. ワクチン接種歴 Vaccination history

MMRV (Measles, Mumps, Rubella, Zoster)..... Time(s) () Mumps..... Time(s) () Hepatitis B..... Time(s) ()
MMR (Measles, Mumps, Rubella)..... Time(s) () Chicken pox..... Time(s) () Meningitis..... Time(s) ()
MR (Measles, Rubella)..... Time(s) () Polio..... Time(s) ()
M (Measles)..... Time(s) () Diphtheria Pertussis Tetanus combined..... Time(s) ()

6. 検査 Laboratory tests

検尿 Urinalysis: glucose (), protein (), occult blood () • 検便 Feces: Parasite(egg of parasite)(+, -)
赤沈 ESR: _____ mm/Hr, WBC count: _____ x10³/μl, Hemoglobin: _____ g/dl, ALT: _____ u/l
Pregnancy test () if you are female

7. 診断医の印象を述べて下さい。 Please describe your impression.

8. 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は十分に留学に耐えうるものと思われますか?
In view of the applicant's history and the above findings, is your observation his/her health status is adequate to pursue studies in Japan? yes no

日付 Date: _____ 署名 Signature: _____

医師氏名 Physician's Name in Print: _____

検査施設名 Office/Institution: _____

所在地 Address: _____