

Personal information Please correct any mistakes in your information with a red pen.

Sponsoring group or company	()	Date of health check		Receipt number	
Insurance number		Site of health check		Health insurance card code	
Furigana		Health check course		Health insurance card number	
Name		Date of birth	age	世帯・所属コード	
Address	〒	Department	Sex	地区コード	
		Personal code		区分・組コード	
		Phone number	()		

Please fill out this form and submit it on the day of your health check. Use a black lead pencil to clearly check your answers, and write numbers clearly and legibly.

(1) Medical History: Past and Present Illnesses

	<input checked="" type="checkbox"/> None	Under medication treatment at a medical institution	Under observation at a medical institution	Past illness	Past surgical history
1 High blood pressure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2 Diabetes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3 Cholesterol and lipid disorders	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4 Anemia	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5 Heart disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specific heart diseases:					
30 <input checked="" type="checkbox"/> Angina	31 <input checked="" type="checkbox"/> Myocardial infarction	32 <input checked="" type="checkbox"/> Valvular disease			
33 <input checked="" type="checkbox"/> Arrhythmia	34 <input checked="" type="checkbox"/> Myocardial disease	35 <input checked="" type="checkbox"/> Other cardiovascular disease			
6 Kidney disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7 Eye disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8 Stroke (cerebral infarction, intracerebral hemorrhage, subarachnoid hemorrhage)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9 Respiratory disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10 Hyperuricemia	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11 Prostate disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
12 Gastric/esophageal disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Specific gastric/esophageal diseases:					
25 <input checked="" type="checkbox"/> Gastric ulcer	26 <input checked="" type="checkbox"/> Duodenal ulcer	27 <input checked="" type="checkbox"/> Gastric polyp			
28 <input checked="" type="checkbox"/> Chronic gastritis	29 <input checked="" type="checkbox"/> Other stomach or esophageal disease (Including Helicobacter pylori eradication.)	Surgery S.H.			
13 Intestinal disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
14 Liver disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
15 Biliary tract disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
16 Pancreatic disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
17 Thyroid disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18 Osteoporosis	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
19 Depression	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
20 Orthopedic disorder	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
21 Gynecological condition	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
22 Breast disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
23 Ear disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24 Other disease	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

(2) In the past year, have you noticed any of the following symptoms? Please mark all that apply.

1 <input checked="" type="checkbox"/> Numbness in hands or feet	9 <input checked="" type="checkbox"/> Excessive thirst	18 <input checked="" type="checkbox"/> Blood in stool
2 <input checked="" type="checkbox"/> Chest pain	10 <input checked="" type="checkbox"/> Weight gain	19 <input checked="" type="checkbox"/> Constipation (3 days or more)
3 <input checked="" type="checkbox"/> Palpitations	11 <input checked="" type="checkbox"/> Weight loss	20 <input checked="" type="checkbox"/> Feeling of incomplete defecation
4 <input checked="" type="checkbox"/> Arrhythmia	12 <input checked="" type="checkbox"/> Lack of appetite	21 <input checked="" type="checkbox"/> Persistent cough or phlegm production
5 <input checked="" type="checkbox"/> Loss of consciousness	13 <input checked="" type="checkbox"/> Lethargy/fatigue	22 <input checked="" type="checkbox"/> Blood in phlegm (during the past 6 months)
6 <input checked="" type="checkbox"/> Shortness of breath	14 <input checked="" type="checkbox"/> Abdominal pain	23 <input checked="" type="checkbox"/> Difficulty urinating
7 <input checked="" type="checkbox"/> Dizziness	15 <input checked="" type="checkbox"/> Heartburn/belching	24 <input checked="" type="checkbox"/> Frequent urination
8 <input checked="" type="checkbox"/> Swelling or puffiness in face or limbs	16 <input checked="" type="checkbox"/> Feeling of something stuck in throat	25 <input checked="" type="checkbox"/> Pain in lower back and/or joints
99 <input checked="" type="checkbox"/> Other		

(3) Eating and drinking (The last time you finished eating or drinking

※Excludes water that does not contain sugar (tea, water)

☒ Yesterday ex (Hour : 0~23) (Minute : 0~59) Have you taken any medication today? ☒ yes ☒ no

☒ Today ☒ hour ☒ min

Medical examination institution entry field ☒ underlying disease ☒ Urine test not performed

(4) Family History

Please mark all that apply.

	Cancer						Stroke	High blood pressure	Heart disease	Diabetes	Thyroid disease	Sudden death
	Stomach	Colorectal	Uterine	Breast	Lung	Other						
Father	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mother	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Brother/Sister	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Child	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Grandparent, aunt or uncle										<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

(5) When was your last health/medical checkup, and were any irregularities found

If the last consultation was in 2024

(entry example) ※R stands for "Reiwa"

	Health check	Health check	Stomach	Colorecta	Uterus	Breast	Lung	Prostate
Year	R 6	R	R	R	R	R	R	R
Irregularities	Y • N	Y • N	Y • N	Y • N	Y • N	Y • N	Y • N	Y • N
Follow-up tests	C • N	C • N	C • N	C • N	C • N	C • N	C • N	C • N

Please write about your most recent health checkup using the Japanese calendar. You do not need to fill out this form if you have not had a health check in the past 6 years or more.

*This form will be machine scanned, so please do not stain, fold or bend this form.

Please continue to the reverse side of this form

How often do you drink alcohol?

<input checked="" type="checkbox"/>	1. Every day	<input checked="" type="checkbox"/>	2. 5-6 days a week	<input checked="" type="checkbox"/>	3. 3-4 days a week
<input checked="" type="checkbox"/>	4. 1-2 days a week	<input checked="" type="checkbox"/>	5. 1-3 days a month	<input checked="" type="checkbox"/>	6. Less than 1 day per month
<input checked="" type="checkbox"/>	7. Stopped	<input checked="" type="checkbox"/>	8. No drinking habit		

☒ Less than 1 "go" unit
 ☒ Less than 2 "go" units
 ☒ Less than 3 "go" units
☒ Less than 5 "go" units
 ☒ More than 5 "go" units

● Beer(5%)	500ml	● Shochu(25%)	110ml
● Wne(14%)	180ml	● Whiskey(43%)	60ml
● Can Chu-Hi(5%)	500ml	● Can Chu-Hi(7%)	350ml

<input checked="" type="checkbox"/>	Excellent	<input checked="" type="checkbox"/>	Good	<input checked="" type="checkbox"/>	Average
<input checked="" type="checkbox"/>	Not very good	<input checked="" type="checkbox"/>	Not good		

☒ Yes ☒ Somewhat ☒ Not really ☒ No

☒ I eat three proper meals each day.

☒ Compared with six month ago, I have more difficulty eating hard food.
(*Such as apples, nuts, pizza crust, raw carrots, etc.)

☒ I have lost more than 2-3kg during the past six months.

☒ I go walking or exercise more than once a week.

☒ I am told that I tend to repeat questions or have become forgetful.

☒ I go out at least once a week.


☒ when I feel unwell, there is someone nearby who I can talk to.


								0	5
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• Are you a current smoker? (of conventional tobacco products or heated tobacco products)

☒ I am a current smoker

An average of $\text{Cl}(\quad)$ cigarettes/day for \quad year

g,  years
old

 years
ago

☒ Yes ☒ No

Tobacco type

☒ conventional tobacco products

☒ heated tobacco products

Have you ever undergone Helicobacter pylori eradication therapy? ☒ No ☐ Yes


☒ Successful ☒ Unsuccessful ☒ Don't know

1.Showa    year

Will you have a stomach cancer screening this year?

☒ Yes, I will☒ No, I won't☒ Already examined

If you are post-menopausal, which did you experience?

Natural menopause at age  years old

Postoperative menopause			years old
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Pregnancy and childbirth

Number of births times I have had()Caesarean sections

I have given birth()times Age at last birth()years old

Have you ever had the Human Papillomavirus (HPV) vaccine? ☒ Yes ☒ No

Please mark all that apply.

☒ Abnormal vaginal bleeding 26 ☒ Increased vaginal discharge 27

☒ Pelvic or abdominal pain between menstrual periods ²⁸ ☒ Breast Lump(s) ²⁹

☒ Breast pain 30 ☒ Breast eczema 31

☒ Other ()

About “Breast Awareness”

- Do you know “Breast Awareness”

☒ Yes ☒ No

- Do you take steps such as performing breast selfexaminations or undergoing regular breast cancer screening?

☒ Yes ☒ No