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.

氏名
Name :________________________ , __________________________________ ☐男 Male ☐女 Female 生年月日 Date of Birth : 年齢 Age :
Family name, First name Middle name

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 Pulse ☐整 regular ☐不整 irregular

(3) 視 力 Eyesight : (R)_______ (L)_______ 裸眼 without glasses 色覚異常の有無 color blindness ☐正常 normal ☐異常 impaired

(4) 聴 力 Hearing : ☐正常 normal ☐低下 impaired 言 語 speech : ☐正常 normal ☐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 心臓 Cardiomegaly : ☐正常 normal ☐異常 impaired
↓
異常がある場合 心電図 Electrocardiograph : ☐正常 normal ☐異常 impaired

Describe the condition of applicant's lung.

3. 現在治療中の病気 Disease Treated at Present ☐Yes (Disease:______________________________) ☐No

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

Tuberculosis......☐(. .) Malaria.......☐(. .) Other communicable disease......☐(. .)
Epilepsy......☐(. .) Kidney Disease.....☐(. .) Heart Diseases......☐(. .)
Diabetes......☐(. .) Drug Allergy......☐(. .) Psychosis.....☐(. .)
Functional Disorder in extremities......☐(. .)

5. 検 査 Laboratory tests
検 尿 Urinalysis:glucose ( ),protein ( ),occult blood ( )

赤沈 ESR :_______mm/Hr, WBC count :_______/cmm 貧血 anemia ☐

Hemoglobin:_______gm/dl, GPT:

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

7. 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充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 it 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:____

Please turn over.

The following questions are to be completed by the physician.

(1) Has the participant previously been hospitalized? Yes☐ No☐
If yes, when and for what reason.

(2) Will the participant require any ongoing medication or treatment for any particular condition during the program? Yes☐ No☐
If yes, explain.

(3) Any previous nervous or eating disorders? Yes☐ No☐
If yes, explain.

(4) Any physical limitations that could prevent them from normal activities such as sports, etc. Yes☐ No☐
If yes, explain.