

Questionnaire for Health Checkup

2024年4月からの問診票

Name:

Use a pencil or mechanical pencil to fill in. Draw a diagonal line in of the applicable column and write a number in the column .

1. Smoking (Please indicate if [1] and/or [2] below apply.)

- [1] Have been smoking for the past month
 [2] Have smoked ≥ 6 months or ≥ 100 cigarettes in lifetime

 Neither applies Both [1] and [2] apply Only [2] applies cigarettes a day years

2. Alcohol

Yes →

 days a week No 1-3 days a month go/day< Rough indication of 1 go of
15% sake (180 mL)>
5% beer (about 500 mL)
25% shochu (110 mL)
14% wine (180 mL)
43% whiskey (60 mL)
7% canned chuhai (350 mL)

3. About recent subjective symptoms (Please choose symptoms that particularly concern you up to 5 items.)

<input type="checkbox"/> Headache/feeling heavy in the head	<input type="checkbox"/> Malaise/feelings of weakness	<input type="checkbox"/> Mucosal inflammation/abnormality	<input type="checkbox"/> Abnormal reflex of patellar tendon/Achilles tendon	<input type="checkbox"/> Cyanosis
<input type="checkbox"/> Pale	<input type="checkbox"/> Reduced/impaired visual acuity	<input type="checkbox"/> Skin inflammation/abnormality	<input type="checkbox"/> Parkinsonian symptoms	<input type="checkbox"/> Abnormal urination
<input type="checkbox"/> Dizziness/Vertigo	<input type="checkbox"/> Conjunctival/corneal abnormality	<input type="checkbox"/> Skin/eye irritation	<input type="checkbox"/> Pain in the distal part of the limbs	<input type="checkbox"/> Defecation abnormality
<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Pain in the eye(s)/blurred vision	<input type="checkbox"/> Respiratory/upper respiratory tract irritation	<input type="checkbox"/> Numbness/paralysis of the limbs	<input type="checkbox"/> Abnormal sweating
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Photophobia (dazzling)	<input type="checkbox"/> Pharyngeal pain/discomfort	<input type="checkbox"/> Movement disorder such as finger tremor	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Abnormal taste	<input type="checkbox"/> Lacrimation	<input type="checkbox"/> Scratchy throat	<input type="checkbox"/> Abnormal sensation	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Nosebleed/pain in the nose	<input type="checkbox"/> Chest pain/tightness	<input type="checkbox"/> Convulsion	<input type="checkbox"/> Nothing in particular
<input type="checkbox"/> Anxiety/restlessness	<input type="checkbox"/> Abnormality in the nasal cavity	<input type="checkbox"/> Palpitation	<input type="checkbox"/> Joint pain/muscle pain [Only for persons who undergo blood sampling]	<input type="checkbox"/> Pregnant or possibly pregnant [Only for women]
<input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Abnormal respiratory symptoms/asthma	<input type="checkbox"/> Abdominal pain/sense of abnormality	<input type="checkbox"/> Decreased grip strength	<input type="checkbox"/> Have felt sick by blood sampling
<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Abnormal breath sounds	<input type="checkbox"/> Change in teeth or discoloration	<input type="checkbox"/> Gait disturbance	<input type="checkbox"/> Have had rash due to alcohol disinfection
<input type="checkbox"/> Excitability	<input type="checkbox"/> Frequent coughing	<input type="checkbox"/> Gingivitis/stomatitis	<input type="checkbox"/> Ataxia	<input type="checkbox"/> Have had numbness in hands after blood sampling
<input type="checkbox"/> Fatigue/fatigability	<input type="checkbox"/> Frequent sputum	<input type="checkbox"/> Enlargement of lymph nodes of neck, etc.	<input type="checkbox"/> Poor writing	

4. Past/present medical history * Enter medical history in the table on the right.

Simple survey on working conditions	(1) Exposure to the relevant substances in the event of accident or repair	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
working exhaust ventilation	(2) Use of local	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Use of protective equipment
Not installed	(3)	<input type="checkbox"/> Always	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Glasses <input type="checkbox"/> Gloves <input type="checkbox"/> Protective clothing

 Use of protective equipment Not use Mask Other

Medical history

Please place a checkmark in each right box below the name of a disease that you have had or for which you are undergoing treatment. In addition, please fill your age when you were affected by the disease.

If you have no medical history, please place a checkmark in the right blank box.

 No past history/present illness

	Past	Under treatment	Outpatient / No medicine	code			Past	Under treatment	Outpatient / No medicine	code			Past	Under treatment	Outpatient / No medicine	code
«Gastric/duodenal disease»																
Chronic gastritis				53	Nephritis					70	Fracture				79	
Gastric ulcer				55	IgA nephropathy					238	Lumbago				66	
Duodenal ulcer				56	Nephrosis					71	Disk herniation				68	
Gastric polyps				54	Pyelonephritis					186	Spinal column stenosis				209	
Gastric submucosal tumor				163	Hemodialysis					72	Gonarthrosis				210	
Gastric diverticulum				151	Nephrolithiasis/urolithiasis					73	Coxarthrosis				211	
Helicobacter pylori positive				164	Prostatitis					187	Shoulder periarthritis (frozen shoulder)				212	
Gastric cancer				6	Prostatic hyperplasia					74	Osteoporosis				67	
Other diseases				121	Cystitis					128	Neuralgia				137	
«Esophageal disease»																
Reflux esophagitis				178	Renal cancer					188	Cervical spondylosis				213	
Esophageal hiatal hernia				147	Prostate cancer					189	Scoliosis				148	
Esophageal varices				160	Bladder cancer					190	Rheumatism				65	
Esophageal carcinoma				162	Other diseases					131	Other diseases				69	
Other diseases				120	Atopic dermatitis					100	Systemic lupus erythematosus				214	
«Colonic disease»																
Colonic polyp				57	Urticaria					191	Scleroderma				215	
Irritable bowel syndrome				155	Chronic eczema					192	Dermatomyositis				216	
Ulcerative colitis				117	Benign skin tumor					193	Multiple sclerosis				217	
Crohn's disease				153	Burn					80	Myasthenia gravis				218	
Colon diverticulum				152	Herpes zoster					194	Sjogren's syndrome				219	
Intestinal obstruction (ileus)				116	Skin cancer					195	Other diseases				52	
Colon/rectal cancer				7	Other diseases					99	«Mammary gland disease»				159	
Other diseases				122	Cerebral infarction					41	Mastitis				159	
«Gallbladder/hepatic/pancreatic disease»																
Gall bladder polyp				58	Cerebral hemorrhage					40	Mastopathy				75	
Gallstone				59	Hydrocephalus					196	Galactocele				158	
Cholecystitis				60	Parkinson's disease					197	Fibroadenoma				157	
Hepatitis				82	Epilepsy					24	Benign mammary neoplasm				92	
Hepatitis B				3	Facial palsy					198	Breast cancer (right)				171	
Hepatitis C				4	Brain tumor					199	Breast cancer (left)				172	
Fatty liver				61	Meningitis					244	Other diseases				239	
Liver cirrhosis				62	Other diseases					97	Uterine myoma				76	
Pancreatitis				63	Anemia					201	Endometriosis				129	
Bile duct cancer				179	Purpura					202	Uterine body cancer				175	
Hepatic cancer				138	Aplastic anemia					203	Ovarian cancer				177	
Pancreatic carcinoma				180	Leukemia					204	Other diseases				133	
Other diseases				64	Multiple myeloma					205	Other diseases				226	
«Eye disease»																
Cataracta				27	Other diseases					206	Other diseases				174	
Glaucoma				28	Hyperthyroidism					207	Uterine cervical cancer				174	
Retinal detachment				181	Hypothyroidism					208	Ovarian body cancer				175	
Age-related macular degeneration				182	Goiter					209	Ovarian cancer				177	