健康診断問診票

2025年03月21日印刷 101

A 0 0 9 9 0 0 0 0 0 0 2 1 0 0 1 A

英語サンプル

個人番号

団体番号

団体名

団体住所

フリガナ

氏名 様

性別 男 女

生年月日 西暦 年 月 日

雇用年月日

①
②
③
④
⑤

所・W・読

健保名 保険者番号 記号 番号 枝番

本人 家族 配偶者

基本	採血	心電図	胸部	胃部	大腸	腹部超音波	眼底	眼圧	呼吸機能	乳	子宮

Please fill in the red box with a pencil

Please do not bend, smear, or cut the consultation ticket as it is processed by machine

Current occupation (one main thing)

① Production process /labor work ② Transportation communications jobs ③ Service job ④ Sales position ⑤ Clerical job ⑥ Sales staff

⑦ Agriculture, forestry and fishery jobs ⑧ Specialized technical position ⑨ Management ⑩ Security job ⑪ Student/Housewife/ Unemployed

Special Operations

	Current	Past
① Organic		
② Lead		
③ Dust		
④ Asbestos		
⑤ Ionizing radiation		
⑥ Specified chemical substances		
⑦ Information equipment work (VDT)		
⑧ Vibration tool		
⑨ Noise site		
⑩ Others ( )		
⑪ Heavy objects: heavy loads, nursing care work, etc		

Working system

①Full-time day shift
②Night shift all the time
③Shift system (both day shift and night shift)

Average working hours per day (last month)

① Less than 6 hours
② Less than 6 to 8 hours
③ Less than 8 to 10 hours
④ 10 hours or more

Average number of working days per week (last month)

① Less than 3 days
② Less than 3-5 days
③ 5 days
④ 6 days or more

◎ Please fill in the question information marked ◎(if not marked ◎, it is not necessary to fill in)

For those who can undergo chest X-ray/chest CT examination

Did you have a chest X-ray or chest CT scan for your health check last year? Yes No

For those who can undergo colon cancer screening (fecal occult blood test)

For those who can undergo colon cancer screening (fecal occult blood test) Yes No

Does anyone in your family have colorectal cancer? No Don't Know (Fiest time) Yes (grandparents parents children siblings)

For those who can undergo gastric cancer screening (barium)

Have you ever had allergic symptoms during a barium test (hives, difficulty breathing, etc.) Yes No Don't Know (Fiest time)

※Unable to undergo gastric cancer screening

Do any of the following apply to ①, ②, ③, and ④ of those who need to be careful during gastric cancer screening in the attached sheet (or on the back)? Yes No

Have you ever had surgery on the esophagus, stomach, duodenum, or large intestine? Yes No

Have you had a stomach cancer screening (barium or gastroscopy) within the past 3 years? Yes No

Have you ever received eradication treatment for Helicobacter pylori in the past? Yes No Don't Know (Fiest time)

Are you currently infected with Helicobacter pylori? Yes No Don't Know (Fiest time)

Gastric cancer risk stratification test (ABC classification) For those who can undergo pepsinogen test

1	Do you have stomach or other digestive symptoms?	Yes	No
2	Are you undergoing treatment (taking medication) for gastric ulcer, duodenal ulcer, reflux esophagitis, etc.?	Yes	No
3	Are you taking PPIs (proton pump inhibitors or Takecab) to suppress stomach acid?	Yes	No
4	Have you ever had gastric surgery (gastrectomy)?	Yes	No
5	Have you been diagnosed with chronic renal failure?	Yes	No
6	Have you ever received eradication treatment for Helicobacter pylori?	Yes	No
7	Do you have a history of any illness that requires long-term use of antibiotics (pneumonia, otitis media, empyema, etc.)?	Yes	No
8	Have you been diagnosed with immunodeficiency/immunocompromise, or are you taking steroids?	Yes	No

***If you answer "yes" to the above questionnaire, the test cannot be performed because the test cannot be determined correctly.**

【個人情報の取り扱い】当協会は以下の目的で個人情報を利用いたします。
・健康診断の契約、事前準備、受付、実施、結果作成、確実な納品および事後処置。
・精度管理および公衆衛生向上のための学術的貢献。この目的で個人情報を利用する際は、個人を特定できない対策を講じます。
・受診いただく検査項目は、健康診断を依頼される団体等との契約・取り決めに基づき実施いたします。

一般財団法人 石川県予防医学協会
ISO9001 認証取得・日本総合健診医学会優良総合健診施設
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CZ11-0011-001

Please write in the red frame with a pencil.

Are you taking the following A.B.C medicines?	Yes	No
a. Medicines that lower blood pressure	☐	☐
b. Blood sugar-lowering drugs or insulin injections	☐	☐
c.Cholesterol and triglyceride drugs	☐	☐
Have you ever been told by a doctor that you had a stroke (cerebral hemorrhage, cerebral infarction, etc.) or received treatment?	☐	☐
Have you ever been told by a doctor that you have a heart disease (angina pectoris, myocardial infarction, arrhythmia, etc.) or received treatment?	☐	☐
Have you been told by a doctor that you have chronic kidney disease or kidney failure, or have you received treatment (such as artificial dialysis)?	☐	☐
Have you ever been told by a doctor that you have anemia (including indications from a medical checkup doctor)?	☐	☐
I have gained more than 10 kg since I was 20 years old	☐	☐
Have been doing light sweat-inducing exercise for at least 30 minutes at a time, at least twice a week for over a year	☐	☐
Walking or doing equivalent physical activity for at least 1 hour a day in daily life	☐	☐
Walking faster than other people of the same age	☐	☐
I am well-rested through sleep	☐	☐
Skipping breakfast three or more times a week	☐	☐
Eating dinner within 2 hours before going to bed 3 or more days a week	☐	☐
I'm trying to be as hungry as possible	☐	☐
I try to eat more vegetables and seaweed	☐	☐
I'm avoiding salt	☐	☐

Do you consume snacks or sweet drinks in addition to the three meals of breakfast, lunch, and dinner?

☐ ① every day ☐ ②sometimes ☐ ③hardly ingested

How fast do you eat compared to other people?

☐ ①Fast ☐ ②Normal ☐ ③ Slow

State when chewing food

☐ ① I can chew and eat anything

☐ ② There are areas of concern such as teeth, gums, and bite that may make it difficult to chew

☐ ③ Hardly chewed

Do you want to improve your lifestyle habits such as exercise and eating habit

☐ ① I have no intention of improving

☐ ② I intend to improve (within 6 months)

☐ ③ I intend to improve in the near future and am starting gradually (within a month)

☐ ④ Already working on improvements (within 6 months)

☐ ⑤ Already working on improvements (more than 6 months)

Have you ever received specific health guidance regarding improving your lifestyle habits?

☐ ①Yes ☐ ②No

Past or Present illness

1. Under treatment (taking medication)
2. Healing
3. Follow-up (including dietary therapy)
4. Leave alone

	Diagnosis age	Situation
☐ ①Nothing in particular		
☐ ③ High blood press	88 歳	8
☐ ⑨ Diabetes	88 歳	8
☐ ⑧ Dyslipidemia (Abnormalities in Cholesterol and Triglycerides)	88 歳	8
☐ ④ Stroke	88 歳	8
☐ ⑤ Myocardial infarction Angina pectoris	88 歳	8
☐ ⑥ Arrhythmia	88 歳	8
☐ ⑬ Chronic kidney disease (Nephritis, Nephrosis, etc)	88 歳	8
☐ ⑭ Chronic renal failure Artificial dialysis	88 歳	8
☐ ⑳ Anemia	88 歳	8
☐ ② Cancer Part etc ( )	88 歳	8
☐ ⑩ Hepatitis	88 歳	8
☐ ⑪ Gastric ulcer Duodenal ulcer	88 歳	8
☐ ⑫ Other Digestive diseases ( )	88 歳	8
☐ ⑮ Kidney stones Ureteral stones	88 歳	8
☐ ⑰ Pulmonary tuberculosis Pleurisy	88 歳	8
☐ ⑱ Asthma	88 歳	8
☐ ㉑ Hyperuricemia (including Gout)	88 歳	8
☐ ㉒ Thyroid disease	88 歳	8
☐ ㉕ Other diseases 1 ( )	88 歳	8
☐ ㉖ Other diseases 2 ( )	88 歳	8

Tobacco (including new cigarettes)

☐ ① Smoking※ I have been smoking for the past month

☐ ② Used to Smoke※ I haven't smoked in the past month

☐ ③ Do not Smoke

Average per day 888 cigarette

Duration of smoking 88 year

*Have smoked for more than 6 months in your lifetime, or have smoked a total of 100 cigarettes

Symptoms in the last 3 months

☐ ①Nothing in particular

☐ ② Ringing in my ears

☐ ③ Cough and Phlegm

☐ ④ Blood Sputum (within 6 months) ➡Seek immediate medical attention

☐ ⑤ Sometimes Headaches or Heaviness

☐ ⑥ Dizziness or Standing Dizziness

☐ ⑦ Chest pain or Feeling of pressure in Chest

☐ ⑧ Pulse may be irregular

☐ ⑨ Palpitations and shortness of breath

☐ ⑩ Back Pain

☐ ⑪ Severe stiff shoulders

☐ ⑫ Pain or discomfort in the Stomach

☐ ⑬ No Appetite

☐ ⑭ Prone to Diarrhoea

☐ ⑮ Frequent difficulty Sleeping

☐ ⑯ Fatigue and Tiredness

☐ ⑰ Other(within 10 characters) ( )

Alcohol

Drinking frequency (sake, shochu, beer, Western liquor, etc.)

☐ ①Every day ☐ ⑦Quit

☐ ②5-6 days ☐ ⑧I don't drink (I can't drink)

☐ ③3-4 days

☐ ④1-2 days a week

☐ ⑤1 to 3 days a month

☐ ⑥Less than 1 day a month

Amount of alcohol consumed per day on drinking days

☐ ①Less than 1 cup

☐ ②Less than 1-2 cup

☐ ③Less than 2-3 cup

☐ ④Less than 3-5 cup

☐ ⑤5 cup or more

1 cup of Sake (15% alcohol, 180mL)
=
Beer (5% alcohol, 500mL)
Shochu (25% alcohol, 110mL)
Wine (14% alcohol, 180mL)
Whiskey (43% alcohol, 60mL)
Canned Chu-Hi (5% alcohol, 500mL)
Canned Chu-Hi (7% alcohol, 350mL)

For women

Are you menstruating?

☐ Yes ☐ No

Are you pregnant

☐ pregnant ☐ Possibility of pregnancy ☐ No

※Unable to undergo Lung cancer/ Stomach cancer Screening