

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: _____, _____, _____
 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 _____ cm 体重 _____ kg
 Height Weight
- (2) 血圧 _____ mm/Hg ~ _____ mm/Hg 血液型 Blood Type

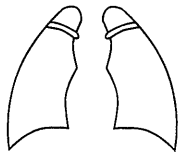
A	B	O
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 RH

+	-
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 脈拍 ☐整 regular
 Blood pressure Pulse ☐不整 irregular
- (3) 視力 Eyesight: (R) _____ (L) _____ (R) _____ (L) _____
 裸眼 without glasses 矯正 with glasses or contact lenses 色覚異常の有無 ☐正常 normal
 color blindness ☐異常 impaired
- (4) 聴力 ☐正常 normal 言語 ☐正常 normal
 Hearing: ☐低下 impaired speech: ☐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 ☐正常 normal
 lung: ☐異常 impaired
 ← Date _____
 Film No. _____
 Describe the condition of applicant's lung.

心臓 ☐正常 normal
 Cardiomegaly: ☐異常 impaired
 ↓
 異常がある場合
 心電図 Electrocardiograph: ☐正常 normal
☐異常 impaired

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

4. 既往症 Past history: Please indicate with + or - 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 ☐
 Hemoglobin: _____ gm/dl, GPT: _____ anemia

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

7. 志願者の既往症、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 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: _____