				Registration nu	umber			
1 1 M	ledical Questionnai	re 1 ✦All items r	nust be filled in \blacklozenge					
Corporate name								
Furigana Mr. / <example entry=""></example>								
Full name				Mrs.	•12345	67890		
Subjective symptoms: Please select any symptoms which you are currently concerned about. I consent to this clinic's handling / purpose of use of my personal information. (The clinic will not use this information for purposes other than medical examination, etc.)								
None in particular O								
Heartburn	Have diarrhea	Have palpitati	ons O Dizziness	0	Do you consent to the reporting of the results of you I agree	ur medical examination to your company and insurer?		
Stomach feels heavy	Often constipated	Have shortness of b	reath O Tinnitus	0	◆ Women only plea	ase select		
Gastric pain	Irregular pulse	Have a cough / ph	legm O Floating sen	sation 🔘	Are you pregnant?	Currently pregnant		
Have no appetite 🔘	Chest pain	Headache	O Very forgetf	ul 🔘	No	There is a possibility		
Abdomen pain	Arthralgia	Backache	Difficult to form	words 🔘	Are you menstruating?	Yes 🔘		
Bloody stool / black stool	Have stress					No		
Current medical his	story: Currently, are ye	ou regularly attendi	ing a hospital (doctor's	surgery / clin	ic)? (See attachment for o	codes of disease names <u>)</u>		
	The disease names filled ir If you are filling in multiple		t. * If the space in the box enter them in the disease nam		nere is no problem filling in anywl column for other diseases.	here outside the box.		
	Attending hospital as an outpatient				y taking Ploase select the	e disease name code.		
Hypertension	\bigcirc	\bigcirc	Cardiovascular disease (such as heart disease)		Name of disease	8 8 8		
Diabetes	\bigcirc	\bigcirc	Brain disease		Name of disease	888		
Dyslipidemia	\bigcirc	0	Gastrointestinal disease (such as stomach disease / hepatic- biliary-pancreatic disease / colon disea	ise)	Name of disease	8 8 8		
Gout / hyperuricemia	\bigcirc	\bigcirc	Blood disease		Name of disease	888		
Allergy	\bigcirc	\bigcirc	Kidney disease	0	Name of disease	8 8 8		
Epilepsy	\bigcirc	0	Urological disease (including the prostate)		Name of disease	888		
Dialysis	\bigcirc	\bigcirc	Respiratory disease	0	Name of disease	8 8 8		
Sleep apnea syndrome	\bigcirc	0	Thyroid disease		Name of disease	888		
Rheumatism	\bigcirc	0	Eye disease	0	Name of disease	8 8 8		
* If you are attending hospital regularly for a	condition other than any of the above dis	seases, please enter the disease na	^{me.} Gynecological disea	se 💽 🤇	Name of disease ()	888		
Madical history	ave you had only n	naior illnoso (incl	uding surgery) in the	nact?				
None in particular	iave you nau any n	Name of disea	uding surgery) in the ase	μαοι				
I have (please enter details in the column on the right) () 888 () 888								
· · · · · ·		() 8 (8 8	(888		
♦ Family history: Have any of your relatives suffered from any of the following illnesses?								
	ave any of your rela		om any of the follow Disease name (condition)	-	Siblings			
Nobody in particular			Cancer	0				
			Hypertension					
Disease name (condition)	Grandparents Paren	is Sibilitys						
Diabetes	0		Hyperlipidemia	0				

	Registration number							
1 5 Medical Questionnaire 2 All specified items mu	t be filled in ◆							
Please answer the medical examination questions								
	smoke, but I haven't I haven't History of smoking	ar 8 8 Cigarettes /day No						
How often do you drink alcohol? *"Quit drinking" refers to those who previously were in the habit of drinking at least once per month, but who have not consumed alcoholic beverages in the past year or more								
Every day 5-6 days 3-4 days 1-2 days 1-3 days per month Per month Quit Can't drinking Can't drink)								
Amount of alcohol consumed per day on drinking days Approximate quantity per unit: beer (5%, 500 ml), shochu (25%, approx. 110 ml), Less than 1-2 Less than 1-2 Less than 2-3 Less than 3-5 5 units or more vine (14%, 180 ml), chuhai (7%, 350 ml), Japanese sake (15%, 180 ml) 1 unit Less than 1-2 units units Units Less than 2-3 Less than 3-5 5 units or more								
Have you ever been told by a doctor that you have cerebral apoplexy (cerebral bleeding or cerebral infarction etc.), or have you ever been treated for	? Yes	No 🔘						
Have you ever been told by a doctor that you have heart disease	Yes	No 🔘						
(angina pectoris or coronary etc.), or have you ever been treated for it? Have you been told by a doctor that you have chronic kidney disease or received treatment (such as artificial dialysis)?								
I have been told by a doctor that I am anemic.	Yes	No 🔘						
My weight has increased by more than 10 kg since I was 20 years old.	Yes	No O						
I eat a meal within 2 hours of going to bed more than 3 times a week.	Yes	No 🔘						
I skip breakfast more than 3 times a week.	Yes	No 🚫						
Compared to other people my speed of eating is	Fast OUsua	Slow O						
Do you consume snacks and sugary drinks between your 3 meals a day	? Every day 🔘 Sometimes	l don't						
How you chew and eat meals I can chew and	eat everything O Sometimes it is hard to chew	I can't chew						
I have done light, sweat-inducing exercise for at least 30 minutes per session for a year.	at least two days a week for over Yes	No 🔘						
I walk or perform equivalent physical activity for at least 1 hour a day in	ny daily life. Yes	No 🔘						
I walk fast compared with others of around the same age and sex as me	. Yes	No 🔘						
I get enough rest through sleeping	Yes	No 🔘						
Do you think you will try to improve your lifestyle habits regarding exercise and eating etc.? (Select one only)								
I don't intend to try to improve them I intend to try to improve them (within 6 months) I am already making efforts to improve them I am already making ef								
I am already making efforts to improve them (for under 6 months)								
Have you ever received specific health guidance about improving your	No 🔾							
 History of working in a dusty environment: yes/no Welding, polishing, crushing work etc. 	Yes	No O						
Registration information	Correction, cl	nange						

Medical questionnaire list of codes for disease names

* In order to make a more accurate judgment, please use the following disease name codes when filling in the medical questionnaire.

Classification	Number	Name of disease	Classification	Number	Name of disease
Brain disease	11	Cerebral infarction (stroke)		606	COPD
	12	Cerebral hemorrhage / Subarachnoid hemorrhage	Respiratory disease	607	Asthma
	13	Brain tumor		608	Lung cancer
	999	*Other		999	*Other
Blood disease	101	Anemia	-	701	Nephritis
	102	Polycythemia		702	Nephrosis
	103	Leukemia		703	Kidney cancer
	999	*Other	Kidney /	704	Chronic renal disease
Eye disease	201	Glaucoma	urological diseases	705	Prostate disease
	202	Cataract	1	706	Prostate cancer
	999	*Other	1	707	Prostatic hypertrophy
	301	Hyperthyroidism (Graves' disease)	1	999	*Other
F	302	Hypothyroidism (Hashimoto's disease)		751	Viral hepatitis
Thyroid disease	303	Goiter	1	752	Hepatitis
	999	*Other	1	753	Fatty liver
	401	Arrhythmia	Liver / biliary /	754	Liver cancer
ŀ	402	Atrial fibrillation	pancreatic disease	755	Gallstones
ľ	403	Myocardial infarction	1	756	Pancreatitis
	404	Angina		757	Pancreatic cancer
Cardiovascular disease	405	Heart valve disease		999	*Other
	406	Septal defect		801	Uterine leiomyomas
ľ	407	Cardiac hypertrophy	Gynecological disease	802	Ovarian disease
ľ	408	Pacemaker		803	Uterus cancer
ľ	999	*Other	1	804	Breast cancer
	501	Gastric (stomach) ulcer	1	999	*Other
	502	Duodenal ulcer		901	Depression
	503	Reflux esophagitis		902	Insomnia
ľ	504	Gastritis		903	Autonomic ataxia
Gastrointesti nal disease	505	Stomach cancer		999	*Other mental illnesses
	506	Crohn's disease		920	Backache
	507	Ulcerative colitis		921	Disc herniation
	508	Irritable bowel syndrome	Other	999	* Other orthopedic / surgical diseases
	509	Colon cancer	diseases	940	Psoriasis
	999	*Other	1	941	Atopic dermatitis
Respiratory disease	601	Pneumonia		999	*Other types of skin diseases
	602	Bronchiectasis		961	Headache
	603	Emphysema			
	604	Tuberculosis		999	*Other types of cancer
	605	Pneumothorax	1	999	*Other