

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 Examination

(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) _____ (R) _____ (L) _____
裸眼 Without glasses 矯正 With glasses or contact lenses 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 the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).

肺 Lungs: 正常 normal 異常 impaired

心臓 Cardiomegaly: 正常 normal 異常 impaired

← Date _____

Film No. _____

Describe the condition of applicant's lungs.

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 Under medical treatment at present Yes (Conditions/particulars: _____) 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 disease..... (. . .)
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: _____ g/dl, GPT: _____

6. 診断医の印象を述べてください。
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 that 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 (Print): _____

検査施設名 Office/Institution: _____
所在地 Address: _____