様式３

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
□女 Female

生年月日
Date of Birth:

年齢
Age:

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)_____ 裸眼 Without glasses　(R)_____(L)_____ 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
← Date _____
Film No. _____
Describe the condition of applicant's lungs.

心臓 Cardiomegaly: □正常 normal □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 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.

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: _____