

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
---	---	---

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 言語 speech: 正常 normal
低下 impaired 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 lung: 正常 normal
異常 impaired

心臓 Cardiomegaly: 正常 normal
異常 impaired

← Date _____
 Film No. _____

異常がある場合
心電図

Electrocardiograph: 正常 normal
異常 impaired

Describe the condition of applicant's lung.

3. 現在治療中の病気 Disease Treated at Present Yes (Disease: _____) 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
anemia
 Hemoglobin: _____ gm/dl, GPT: _____

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 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: _____