

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 Examinations

- (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 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 ☐正常 normal ☐低下 impaired 言語 ☐正常 normal ☐異常 impaired
Hearing: ☐正常 normal ☐低下 impaired 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 applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).



肺 ☐正常 normal ☐異常 impaired
lung: ☐正常 normal ☐異常 impaired
← Date _____
Film No. _____

Describe the condition of applicant's lung.

心臓 ☐正常 normal ☐異常 impaired
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 ☐ Yes (Disease: _____) ☐ No
Disease Treated at Present ☐ Yes ☐ 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 _____ 署名 _____
Date: _____ Signature: _____

医師氏名
Physician's Name in Print: _____

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