

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: _____, _____, _____
男 Male 生年月日 Date of Birth: _____
女 Female

Family name, First name Middle name

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 Ty

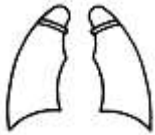
A B O	RH	+
		-

 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 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 six months prior to the certification are NOT valid).



肺 Lungs: 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 lungs.

3. 現在治療中の病気 Disease currently being treated Yes (Disease _____) No

4. 既往症

Past history : Please indicate with + or - and fill in the date of recovery

(If the applicant has not contracted any of the disease, please check "None".) (いずれも該当しない場合は、なしにチェックすること。)

Tuberculosis..... (. . .) Malaria..... (. . .) Other communicable disease..... (. . .)
 Epilepsy..... (. . .) Kidney disease..... (. . .) Heart disease..... (. . .)
 Diabetes..... (. . .) Drug allergy..... (. . .) Psychosis..... (. . .)
 Functional disorder in extremities..... (. . .)

None.....

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。（問題がない場合も、その旨ご記入ください。）

Please give your impression of the applicant's health. (If you do not have a particular opinion, please write as such.)

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 in Print : _____

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

Address: _____