Health Check Questionaire

kana		Birthday	year month day
Name	(M ・ F)		(y.o.)

Do you have any of the illnesses about below?			treatment and date treatment began
Hypertension	Yes	No	
Diabetes	Yes	No	
Abnormal lipid disease	Yes	No	
others	Yes	No	
Have you ever had or been treated for any of the diseases			**treatment and date treatment began**
Cerebrovascular disease	Yes	No	
Cardiovascular disease	Yes	No	
Chronic renal failure, Hemodialysis	Yes	No	
Anemia	Yes	No	
others	Yes	No	
Have you ever had an operation?			**Operation name**
(diagnosis)	Yes	No	

Lifestyle Questions	Choice
Do you smoke?	Yes / No How much cigarettes/day×year ( ) × ( )
Have you gained 10 or more kgs since your 20th birthday?	Yes / No
When you excersise do you lightly sweat? And have you been excercising for 30mins, three times a week for more than 1year?	Yes / No
Do you walk or do a walking level exercise for more than 1 hour in a day?	Yes / No
Is your walking pace faster compared with a person of the same age and sex?	Yes / No
Have you gained or lost 3kgs within the past year?	Yes / No
Do you eat faster compared with other people?	fast / avarage / slow
Do you eat dinner less than 2 hours before sleeping more than 3 times in a week?	Yes / No
Do you eat snacks after dinner more than 3 times in a week?	Yes / No
Do you skip breakfast more than 3 times in a week?	Yes / No
How many times do you consume alcoholic beverages?	everyday / sometimes / rarely
How much do you drink when you drink ? ※ Example of 1 Gou: Sake（180ml), Shouchu35℃（80ml), Beer（500ml) Chuhai 7%（350ml), Whiskey（60ml), Wine（240ml)	less than 0-1 Gou between 1-2 Gou between 2-3 Gou more than 3 Gou
Do you sleep well?	Yes / No
Do you plan to lead a healthier lifestyle in regards to eating habits, exercise, and so on?	No probably improve as soon as possible already improving less than 6 months already improving more than 6 months
If you have an opportunity to recieve instruction for improving your health, do you want it?	Yes / No

※please follow on the other side

Health Check Questionaire

Please check the symptoms you occasionally experience.			
chest pain / tightness	stiff shoulders / back pain	depression	hemorrhoids
palpitation	numbness of arms or legs	stomache bloating	other
shortwindedness	dizziness	diarrhea	( )
sleeplessness	headache / buzzing	constipation	

Have you ever discovered a medical problem with your body by any of the medical procedures listed below in the past 2 years?			
①Electro Cardio Gram ②Ultrasound ③Xray ④Upper GI ⑤other	Yes	No	contents ( )
Have you ever had a hepatitis B shot?	Yes	No	_____years ago, total_____times
Only for ladies			
Is there a possibility that you may be pregnant?	Yes	No	
Are you on your period?	Yes	No	last period: Month_____Day_____started
Do you agree to a Xray test?	Yes	No	

～Policy about personal information～

1．個人情報の取得及び利用目的

受診者様からご登録いただいた個人情報は、次の業務目的に利用します。

1）健康状況把握のための診察・検査等の実施

2）健診結果の報告

3）料金の請求

4）健康診断のご案内及びセミナーのご案内等の発送（個人の住所等をご登録頂いている場合）

5）精度管理、医学教育、研究（個人の識別が出来ない方法で行います）

6）法令・行政上の業務への対応

2．個人情報の委託・提供

1）血液検査については、個人情報保護体制が一定の水準に達していると認められる専門業者を当院が責任を持って選定し、個人情報を提供する場合があります。

2）当院と直接契約（申込み内容）を行い、健康診断を受診された方の結果通知書は、ご本人に直接郵送するか所属先の事業所を経由してお届けします。

3．同意が得られなかった場合

受診者の方から所属事業者名、氏名、性別、生年月日等の基本情報等の提供が得られなかった場合、健診結果データを受診された個人と結びつけることができず、受診者様や所属事業所等へ健診結果報告書の提供ができないことになります。

4．開示・訂正等

1）受診者様が所属する事業所等より委託を受けた個人情報の開示請求は、受診者様が所属する事業所等の担当者を経由して行ってください。

2）当院に直接申込みされたご本人からの開示請求については、相談窓口にお申出ください。
その時は、本人確認できる身分証等でご本人を確認させていただいた後、速やかに開示します。

5．個人情報取り扱い窓口

ラッフルズメディカル大阪クリニック　個人情報取り扱い窓口：06-6345-8145

上記の個人情報の取り扱いについて、同意いただける場合は右の□に✓点をお願いします。