RafflesMedicalGroup

Medical Checkup Questionnaire

Rev.4

Kana		Date of Birth	year month day
Name	(M・F)		(y.o.)

Please check☑ if you have any subjective symptoms.

☐ chest pain/tightness	☐ shoulder stiffness/back pain	☐ depression	☐ hemorrhoids
☐ palpitations	☐ numbness of arms or legs	☐ abdominal bloating	☐ other
☐ shortness of breath	☐ dizziness	☐ diarrhea	( )
☐ sleeping difficulties	☐ headache/ringing of ears	☐ constipation	

Please check☑ if you have any of the following medical problems.

☐current ☐previous stroke	☐current ☐previous ischemic heart disease	☐current ☐previous diabetes mellitus
☐current ☐previous cerebral hemorrhage	☐current ☐previous other heart disease	☐current ☐previous liver disease
☐current ☐previous cerebral infarction	☐current ☐previous anemia	☐current ☐previous gastroduodenal ulcer
☐current ☐previous other cerebrovascular disease	☐current ☐previous high blood pressure	☐current ☐previous depression
☐current ☐previous chronic renal failure	☐current ☐previous low blood pressure	☐current ☐previous osteoporosis
☐current ☐previous dialysis	☐current ☐previous arrhythmia	☐current ☐previous other
☐current ☐previous angina	☐current ☐previous hyperlipidaemia	Name of disease ( )
☐current ☐previous myocardial infarction	☐current ☐previous hyperuricemia	
☐current ☐previous heart failure	☐current ☐previous kidney disease except kidney failure	

Are you taking the following medicines at present?			About treatment(details/onset)
Medication to reduce blood pressure	Yes	No	
Medication to reduce blood suger or insulin injection	Yes	No	
Medication to reduce your level of cholesterol or of neutral fat	Yes	No	
Other(Name of disease)	Yes	No	

Lifestyle Question	Answers
Are you currently a habitual smoker? *"A habitual smoker" means those who meet both conditions 1 and 2. Condition 1: Smoked in the past month Condition 2: Smoked for at least 6 months in his/her lifetime or smoked a total of at least 100 cigarettes	①Yes ②Used to smoke, but not recently in the past month ③No
Have you gained more than 10kg since you were 20?	Yes / No
Do you engage in physical exercise (enough to break mild sweat) at least twice a week for the past one year?／a week for at least 1 year?	Yes / No
Do you walk (or engage in activity of similar intensity) at least 1 hour per day during the day while performing daily activities?	Yes / No
Do you walk faster than people of the same age and sex?	Yes / No
Which of the following applies to you when chewing and eating food?	①No difficulty ②Sometimes difficult to chew ③Hardly chew
Do you eat faster than other people?	Fast / Average / slow
Do you eat dinner within 2 hours before going to bed 3 times or more per week?	Yes / No
Do you take snacks and sweet drinks in addition to breakfast/lunch/dinner?	Everyday / Sometimes / Rarely
Do you skip breakfast 3 times or more per week?	Yes / No
How often do you drink alcohol (sake, shochu, beer, Western-style alcohol, etc.)? *"Quit" means that you habitually drank alcohol at least once a month in the past, but have not drank alcohol for at least one year recently.	①Everyday ②5-6 days a week ③3-4 days a week ④1-2 days a week ⑤1-3 days a month ⑥Less than 1 day a month ⑦Quit ⑧Don't (can't) drink
How much alcohol do you drink per day? *Guideline for 1 cup of sake 15% (180ml): beer 5% (500ml), shochu 25% (110ml), wine 14% (180ml), whiskey 43% (60ml), canned chuhai 5% (500ml), chuhai 7% (350ml).	①Less than 1 cup ②Less than 1-2 cups ③Less than 2-3 cups ④Less than 3-5 cups ⑤More than 5 cups
Do you sleep well and enough?	Yes / No
Do you want to improve your lifestyle, such as exercise and diet?	①Don't want to ②Do want to (within 6 months) ③Want to improve in near future (within a month) and began to start ④Already working on improvement (less than 6 months) ⑤Already working on improvement (more than 6 months)
Have you ever received specific health guidance regarding lifestyle modification?	Yes / No

※ Please follow on the other side.

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Have you had surgery in the past?			Disease name
(Disease name) Example:Cardiac pacemaker, etc	Yes	No	
Have any of the following tests pointed out any abnormalities in the past 2 years?			
①Electro Cardio Gram ②Ultrasound ③X-ray ④Upper GI ⑤other	Yes	No	Details ( )
Only for ladies			
Is there any possibility that you may be pregnant? Are you pregnant?	Yes	No	
Are you currently menstruating?	Yes	No	last period: Month Day started
Do you agree to take an X-ray?	Yes	No	
Only for those who take barium test			**Only if you answer "yes"**
Have you ever had a barium test?	Yes	No	
Have you ever had an allergy to a barium test?	Yes	No	【Allergy】 Valium, laxatives, foaming agents
Have you eaten or drank today? *"Please fast for at least 10 hours."	Yes	No	
Do you find it is difficult to pass stool? How often do you have to defecate?	Yes	No	Date of defecation: 【Frequency】 1-3 days, 4-6 days, One time in a week or more□
Have you ever been told that you have H. pylori?	Yes	No	
Have you ever received a H. pylori treatment?	Yes	No	After treatment ⇒ Negative (Confirmed/Unconfirmed)