

Medical Checkup Questionnaire

Rev.4

Kana		Date of Birth	year	month	day
Name	(M · F)		(

Please check if you have any subjective symptoms.

<input type="checkbox"/> chest pain/tightness	<input type="checkbox"/> shoulder stiffness/back pain	<input type="checkbox"/> depression	<input type="checkbox"/> hemorrhoids
<input type="checkbox"/> palpitations	<input type="checkbox"/> numbness of arms or legs	<input type="checkbox"/> abdominal bloating	<input type="checkbox"/> other
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> dizziness	<input type="checkbox"/> diarrhea	[]
<input type="checkbox"/> sleeping difficulties	<input type="checkbox"/> headache/ringing of ears	<input type="checkbox"/> constipation	

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

<input type="checkbox"/> current <input type="checkbox"/> previous stroke	<input type="checkbox"/> current <input type="checkbox"/> previous ischemic heart disease	<input type="checkbox"/> current <input type="checkbox"/> previous diabetes mellitus
<input type="checkbox"/> current <input type="checkbox"/> previous cerebral hemorrhage	<input type="checkbox"/> current <input type="checkbox"/> previous other heart disease	<input type="checkbox"/> current <input type="checkbox"/> previous liver disease
<input type="checkbox"/> current <input type="checkbox"/> previous cerebral infarction	<input type="checkbox"/> current <input type="checkbox"/> previous anemia	<input type="checkbox"/> current <input type="checkbox"/> previous gastroduodenal ulcer
<input type="checkbox"/> current <input type="checkbox"/> previous other cerebrovascular disease	<input type="checkbox"/> current <input type="checkbox"/> previous high blood pressure	<input type="checkbox"/> current <input type="checkbox"/> previous depression
<input type="checkbox"/> current <input type="checkbox"/> previous chronic renal failure	<input type="checkbox"/> current <input type="checkbox"/> previous low blood pressure	<input type="checkbox"/> current <input type="checkbox"/> previous osteoporosis
<input type="checkbox"/> current <input type="checkbox"/> previous dialysis	<input type="checkbox"/> current <input type="checkbox"/> previous arrhythmia	<input type="checkbox"/> current <input type="checkbox"/> previous other
<input type="checkbox"/> current <input type="checkbox"/> previous angina	<input type="checkbox"/> current <input type="checkbox"/> previous hyperlipidaemia	Name of disease []
<input type="checkbox"/> current <input type="checkbox"/> previous myocardial infarction	<input type="checkbox"/> current <input type="checkbox"/> previous hyperuricemia	
<input type="checkbox"/> current <input type="checkbox"/> previous heart failure	<input type="checkbox"/> current <input type="checkbox"/> 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.

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?			
① Electro Cardio Gram ② Ultrasound ③ X-ray ④ Upper GI ⑤ other	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 <input type="checkbox"/>
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)