Requests Please refer to the entry **example** and fill in with a dark pencil (2B or higher) or a black ballpoint pen Do not fold this paper

This is an example of how to fill out the form, so please do not write it directly on this form

Medical history

Please enter the name of the disease, age of onset, and treatment status.

Treatment status

0.Under treatment (with medication) 1.Under treatment (no medicine)
2.During follow-up 3.healing 4.Surgery 5.Abandoned

☐ no history

[Entry example] heart disease,Onset of illness at the age of 45,If you are on medication

	Disease name	Age of onset	Treatment status
	01	45	0

[Disease name]
01 Heart disease
02 Brain attuck
03 Hypertension
04 Diabetes
05 Kidney trouble
06 Gout
07 Liver disease
08 Dyslipidemia
09 Ophthalmic disease
13 Anemia
14 Gastric or duodenal ulcer
20 Respiratory disease
25 Gynecological diseases
45 Thyroid disease
32 Lung cancer
33 Stomach cancer
34 Colorectal cancer
35 Breast cancer
36 Uterine cancer
37 Prostate cancer
17 Other

	Disease name	Age of onset	Treatment status		Disease name	Age of onset	Treatment status
1				5			
2				6			
3				7			
4				8			

Other disease names
If you entered 17 (other diseases) in the disease name column, please write the specific disease name on the right

Family medical history

	Disease name
1	
2	
3	
4	
5	
6	

Subjective symptoms

Please enter the number of the applicable symptom.

☐ no symptoms

01 Fatigue
03 Weight gain (over 3 kg)
04 Weight loss (over 3 kg)
05 Appetite loss
06 Headache
07 Dizziness or dizzy after standing
08 Sleep disorder
09 Swelling
10 Palpitations or shortness of breath
13 Cough
16 Chest pain / back pain
21 Stomach pain / abdominal pain
23 Constipation
24 Diarrhea
29 Numbness
35 Lower back pain
36 Joint pain / swelling
43 Eye strain / pain
39 Other ( )

1		4	
2		5	
3		6	

Business history

Please fill in the work you have experience

☐ no history

01 High temperature enviroment
02 Low temperature
03 Radiation
04 Dust
05 Abnormal atmospheric pressure
06 Vibration
07 Heavy carryer
08 Lourd sound
09 Under the mine
10 Midnight
11 Hazardous material handling
12 Toxic gas vapor dust
13 Pathogen pollution

1		4	
2		5	
3			

Work status

If you are currently working, please write the appropriate number.

●What kind of work system do you have in your current workplace?
1 Always day shift 2 Always night shift 3 Both day shift and night shift

●What is the average daily working time in the last month at your current workplace?
1 Less than 6 hours 2 6 hours or more and less than 8 hours 3 8 hours or more andless than 10 hours 4 10 hours or more

●What is the average number of working days per week in the last month at your current workplace?
1 Less than 3 days 2 3 days or more and less than 5 days 3 5 days 4 6 days or more

History of Helicobacter pylori elimination	Yes ☐	No ☐
History of gastric resection	Yes ☐	No ☐

Do you consent to our company 's use of your personal information obtained during the health checkup (information on the cover page)? I consent ☐ I do not consent ☐

This is an example of how to fill out the form, so please do not write it directly on this form

Health Renaissance

～Transforming oneself is the first step to health～

Don't cut it here

This is an example of how to fill out the form, so please do not write it directly on this form

Health checkup slip

Smart Life Projectで
健康寿命をのばしましょう。

request

●Fill out pages 2 and 4 with a **dark pencil (2B or higher) or a black ballpoint pen**
●If you have printed your name, date of birth, etc. in advance, please check the contents and correct any errors
●This paper is processed by a machine, so please do not fold or bend it except for perforations

Precautions when filling out the form

Health Renaissance ~ Transforming oneself is the first step to health ~

(public corporation) Member of the National Federation of Occupational Health Organizations
Accreditation by the Organization for Functional Evaluation of Occupational Health Services

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Medical Information and Health Foundation

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Medical Information and Health Foundation website

Specific Health Checkup Questionnaire

● Follow the font example and fill in the appropriate number for each item. Example of typeface 1 2 3 4 5

1	Have you been told by a doctor that you have chronic kidney disease or kidney failure, or are you undergoing treatment (such as artificial dialysis)?		Yes / No
2	Do you currently smoke regularly? (* "A person who is currently a habitual smoker" is a person who satisfies both conditions 1 and 2.)) Condition 1: Smoking for the last 1 month Condition 2: Smoking for more than 6 months in your lifetime, or smoking more than 100 cigarettes in total)	1: Yes (meets both condition 1 and condition 2) 2: I used to smoke, but I haven't smoked for the last 1 month (only condition 2 is satisfied) 3: No (except 1 2 above) Número de cigarros ☐☐ cigarros/dia período ☐☐ Ano	
3	Have you gained more than 10 kg since you were 20 years old?		Yes / No
4	Have you been exercising with light sweating for 30 min. or more at least two days a week for over one year?		Yes / No
5	In your daily life, do you walk or do an equivalent amount of physical activity more than one hour a day?		Yes / No
6	Do you walk faster than other almost same age persons?		Yes / No
7	Which describes your situation when you chew food? ※ Choose from ① to ③ and record your choice in the box to the right	1: Can chew and eat anything 2: Teeth, gums, or dental bite are bothering you, so chewing can be difficult 3: Practically cannot chew	
8	Do you eat faster than those around you?		fast / slow / ordinary
9	Do you eat a meal within two hours of bedtime three or more times a week?		Yes / No
10	Do you eat sweet snacks or sweet drink between meals?	1: Dally 2: Sometimes 3: Rarely	
11	Do you skip breakfast three or more times a week?		Yes / No
12	Are you getting enough sleep and rest?		Yes / No
13	How often do you drink alcohol (Japan sake, shochu, beer, Western sake, etc.)? Conditions for choosing number 7 : (who have a history ofhabitual drinking at least once a month in the past and have not consumed alcoholic beverages for more than one year.)	1: Every day 2: 5~6 days a week 3: 3~4 days a week 4: 1~2 days a week 5:1~3 days a month 6: Less than 1 day per month 7: Quit 8: Don't drink (can't drink)	
14	Approximate for 1 cup ofJapan sake (15%alcohol by volume, 180ml): Beer (5 degrees, 500 ml), shochu (25 degrees, about 110 ml), Wine (14 degrees, about 180 ml), whiskey (43 degrees, 60 ml), Can Chuhai (5°C, approx. 500ml, 7°C, Approx. 350ml)	1: Less than 1:1go 2: Less than1~2 go 3: Less than 2~3 go 4: Less than 3~5 go 5: 5 or more	
15	Do you have plans to improve your exercise habits and lifestyle? ※ Choose from 1 to 5 and record your choice in the box to the right	1: No plans 2: Plan to within the next 6 months 3:Plan to within the next 1 months 4: Already improving (less than 6 months) 5: Already improving (6 months or more)	
16	Have you ever received specific health guidance on improving your lifestyle?		Yes / No

*This questionnaire is a standard questionnaire for conducting periodic health checkups based on the Industrial Safety and Health Act and specific health checkups based on the Act on Securing Medical Care for the Elderly at the same time

Don't cut it here

Corporation name			
name		Sex	Male / Female
Date of birth	T S H Year Month Date	age	years

Insurance classification | division | course | company | place

Por favor, não escreva nada nesta caixa.

blood: Done ☐ ID Number | Blood sampling conditions: after meals ☐☐☐ minutes

Body Measurement: height ☐☐☐.☐ | body weight ☐☐☐.☐ | Body fat percentage ☐☐.☐ | Waist circumference ☐☐☐.☐

Eyesight

	Right naked eye	Left naked eye	Right (correction)	Left (correction)
far point	☐.☐	☐.☐	☐.☐	☐.☐
near point	☐.☐	☐.☐	☐.☐	☐.☐

hearing

1000Hz (dB)	Right ☐☐	Left ☐☐	observation Right ☐	observation Left ☐
4000Hz (dB)	Right ☐☐	Left ☐☐	observation Right ☐	observation Left ☐
Conversational method	observation Right ☐	observation Left ☐	[judgement] 1. observation Findings: Yes 2. observation Findings: No	

Urinalysis

albuminuria	☐	Urine sugar	☐	Urinary urobilinogen ☐
Urinary occult blood	☐	pH	☐	[judgement] 3 : + 1 : — 4 : ++ 2 : ± 5 : +++ ※For PH, enter a number of 5~9.

blood pressure1: Highest ☐☐☐ ~ Lowest ☐☐☐ | During menstruation Yes ☐ No ☐

blood pressure2: Highest ☐☐☐ ~ Lowest ☐☐☐ | During pregnancy ☐ There is a possibility ☐ No ☐

Chest X-ray: indirection ☐ direct ☐ FilmNo. ☐

Gastric examination: indirection ☐ direct ☐ endoscope ☐ FilmNo. ☐

Intraocular pressure: Right ☐☐ Left ☐☐ | Color blindness ☐ | ☐ 1. No abnormalities 2. Red-green color anomaly 3. Total color blindness

Pulmonary function tests

Predicted Vital Capacity (VCP)	☐☐.☐☐	Vital Capacity (CV)	☐☐.☐☐
Ratio of vital capacity (%VC)	☐☐☐.☐	1 second amount (FEV_1)	☐☐.☐☐
1 second rate (FEV_1%)	☐☐☐.☐	%1 second amount (%FEV_1)	☐☐☐.☐

remarks | field of vision ☐ 0. No abnormal 1.abnormal | other ☐☐☐.☐

medical examination observation

observation Number	observation	observation Number	observation
01	tachycardia	13	Palmar erythema
02	Bradycardia	14	Enlarged tonsils
03	arrhythmia	15	tonsillitis
04	Heart murmur	16	Pharyngeal redness
05	Abnormal heart sounds	17	Ocular conjunctival yellowing
06	Abnormal breathing sounds	18	Ocular conjunctival anemia
07	Swelling	19	Ocular conjunctival hyperemia
08	Cervical lymphadenopathy	20	Eyelid conjunctival hyperemia
09	Enlarged thyroid gland	21	Eyelid conjunctival abnormalities
10	Enlarged submandibular adenology	22	Epigastric tenderness
11	Arachnoid hemangioma	23	Bronchial sounds abnormal
12	Drumstick-shaped fingers	24	Pain in the lower back
	☐ No abnormalities	25	Joint abnormalities
		99	other

*Other observations are listed below.

There is an anomaly

observation Number ☐☐ judgement ☐ 1. Follow-up is required 2. Detailed inspection required

observation Number ☐☐ judgement ☐ 1. Follow-up is required 2. Detailed inspection required

observation Number ☐☐ judgement ☐ 1. Follow-up is required 2. Detailed inspection required

other

electrocardiogram		☐	Fundus		Right ☐	Left ☐	
Urine sediment		☐	Fecal occult blood		Primeiro dia ☐	o 2º dia ☐	
expectoration		☐	Breast cancer		☐	cáncer cervical	☐
Abdominal echo		☐	No.				
osteoporosis		☐	osteoporosis Number		Cervical echo ☐	interview ☐	
Special Health Checkups	Pneumoconiosis ☐		Organic solvents ☐		lead ☐	Ionizing radiation ☐	Specified Chemical Substances ☐
	high atmospheric pressure ☐		Tetraalkyl lead ☐		Tooth erosion ☐	asbestos ☐	influenza ☐
other	VDT ☐	ultraviolet infrared ☐			Laser light ☐	noise ☐	vibration ☐
	lumbago ☐	Breast palpation ☐			Mammary gland echo ☐	One-way mammography ☐	Two-way mammography ☐
womb No				mammography No.			
Mammary gland echo No							

Example (Front)

Please be sure to fill out the form in advance so that you can have a smooth checkup on the day of the checkup.

< Precautions when filling out the form >

〇Use a dense pencil(2 B) **Don't go out of the entry field Please fill in the form carefully**

〇Please put a space between the first name and the last name.

団体名					
氏名	カナ		性別	男・女	
	漢字				
生年月日	T S H 年 月 日		年齢	歳	

For other diseases, please enter [17] in the disease name column and enter the disease name in the frame

* If there is more than one [17], please enter the name of each disease.

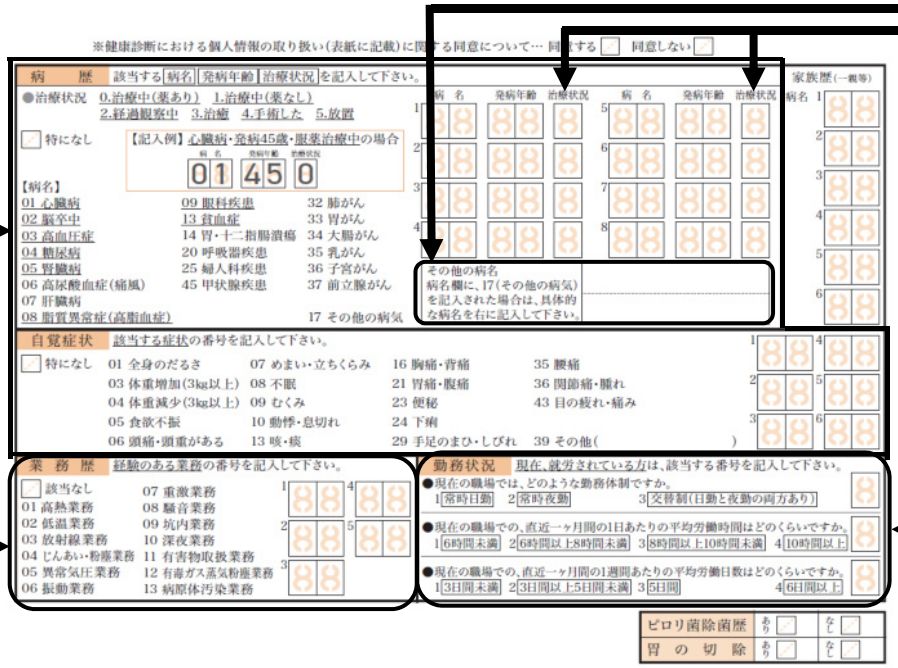
Please fill in only your own information in this frame

If the treatment status is blank, it will be registered in the anamnesis

* [2: Follow-up] is also being treated

Fill in the jobs you have experience in

If you are currently working, please fill in



Example（Back）

If you are 40 years old or older (during the current fiscal year), please be sure to fill in the form
Please be sure to fill in the list of drinking and smoking. Please fill in items other than cigarettes (heat-not-burn cigarettes, etc.)

特定健康診査問診票

●各項目のあてはまる数字を記入字体例にならって記入してください。　記入字体例 1 2 3 4 5

1	医師から、慢性腎臓病や腎不全に罹っていると言われたり、治療（人工透析など）を受けていますか。	はい □	いいえ □
2	現在、たばこを習慣的に吸っていますか。 （※「現在、習慣的に喫煙している者」とは、条件1と条件2を両方満たす場合） 条件1：最近1ヶ月間吸っている 条件2：生涯で6ヶ月間以上吸っている、又は合計100本以上吸っている	1：はい（条件1と条件2を両方満たす） 2：以前は吸っていたが、最近1ヶ月間は吸っていない（条件2のみ満たす） 3：いいえ（上記１２以外） 本数 □□ 本/日　期間 □□ 年	□
3	20歳の時の体重から10kg以上増加していますか。	はい □	いいえ □
4	1回30分以上の軽く汗をかく運動を週2日以上、1年以上実施していますか。	はい □	いいえ □
5	日常生活において歩行又は同等の身体活動を1日1時間以上実施していますか。	はい □	いいえ □
6	ほぼ同じ年齢の同性と比較して歩く速度が速いですか。	はい □	いいえ □
7	食事をかんで食べる時の状態はどれにあてはまりますか。	1：何でもかんで食べることができる 2：歯や歯ぐき、かみあわせなど気になる部分があり、かみにくいことがある 3：ほとんどかめない	□
8	人と比較して食べる速度が速いですか	速い □　遅い □　普通 □	
9	就寝前の2時間以内に夕食をとることが週に3回以上ありますか。	はい □	いいえ □
10	朝昼夕の3食以外に間食や甘い飲み物を摂取していますか。	1：毎　日 2：時　々 3：ほとんどしない	□
11	朝食を抜くことが週に3回以上ありますか。	はい □	いいえ □
12	睡眠で休養が十分とれていますか。	はい □	いいえ □
13	お酒（日本酒、焼酎、ビール、洋酒など）はどの位の頻度で飲みますか。 （※「やめた」とは、過去に月1回以上の習慣的な飲酒歴があった者のうち、最近1年以上酒類を摂取していない者）	1：毎　日 2：週5～6日 3：週3～4日 4：週1～2日 5：月に1～3日 6：月に1日未満 7：やめた 8：飲まない（飲めない）	□
14	飲酒日の1日当たりの飲酒量はどの位ですか。 日本酒1合（アルコール度数15度・180ml）の目安： ビール（同5度・500ml）、焼酎（同25度・約110ml）、ワイン（同14度・約180ml）、ウイスキー（同43度・60ml）、缶チューハイ（同5度・約500ml、同7度・約350ml）	1：1合未満 2：1～2合未満 3：2～3合未満 4：3～5合未満 5：5合以上	□
15	運動や食生活等の生活習慣を改善しようと思っていますか。	1：改善するつもりはない 2：改善するつもりである（概ね6ヶ月以内） 3：近いうちに（概ね1ヶ月以内）改善するつもりであり、少しずつ始めている 4：既に改善に取り組んでいる（6ヶ月未満） 5：既に改善に取り組んでいる（6ヶ月以上）	□
16	生活習慣の改善について、これまでに特定保健指導を受けたことがありますか。	はい □	いいえ □

＊本問診票は、労働安全衛生法に基づく定期健康診断等と高齢者の医療の確保に関する法律に基づく特定健康診査の項目を同時に実施する場合の標準的な問診票です。

Notes Example should be referred to and **pencil** used when filling in this form. Do not fold this form.

Organization name		
Name: Kana		Sex
Name: Kanji		
Date of birth	Year Month Day	Age years old

Department				
Employee No.		Date of employment		Examinee No.

Example ○ × × ☑ ☐ ✓

Example 1 2 3 4 5 6 7 8 9

*Do not to write outside the box.

Example

Name	Kana	fu	ku	o	ka		ji	ro						
	Kanji	福	岡			次	郎							
Date of birth	T Ⓢ H July 7, 1975								Age					

* For Kanji and kana names, leave a space between last name and first name. Write a letter with a diacritic in one space.
* If there is any change in the organization name, department, name, date of birth, or sex, cross out with two lines and write the correct information in blank space, or ask the medical examination site staff.

See **the cover list on page 1** for the work code of organic solvents/lead/ionizing radiation/high pressure/tetraalkyl lead, and see **the list below** for **(1) to (7)**. Strike through any changes and rewrite below.

● Work history

★ See **back side of the Instruction to Fill Out Special Medical Examination Form** for the work code of **pneumoconiosis**.

● Working environment

Breakdown of medical examination * Ask the staff for any addition or change of the items (solvents).	Work code See cover list 1	2	3	Year of handling outside the current company and current work: Year(s)	Month(s)	Handling period (current work) From yyyy/mmm: Year	Month	To yyyy/mmm: Year	Month	(1) Time of medical examination	Average frequency of use: Per day (hour[s])	Per week (day[s])	(2) Work process change	(3) Handling volume/freq uency	(4) Local exhaust ventilation	(5) Use of protective equipment	(6) Type of protective equipment 1	2	3	(7) Accidental massive exposure

This is an example of a stylistic translation of a word, so don't write directly

Name of solvent/substance

● **Exposure dose** — See the list below for (a) to (c).

[Ionizing radiation] Exposure dose after previous medical examination →

(a) Effective dose	(b) Lens	(c) Skin

(a) Effective dose (mSv)	(b) Equivalent dose to eye lens (mSv)	(c) Equivalent dose to skin (mSv)
1. Below detection limit	1. Below detection limit	1. Below detection limit
2. ≤ 5 mSv	2. ≤ 20 mSv	2. ≤ 150 mSv
3. >5 mSv ≤ 20 mSv	3. > 20 mSv ≤ 50 mSv	3. > 150 mSv ≤ 500 mSv
4. > 20 mSv ≤ 50 mSv	4. > 50 mSv	4. > 500 mSv
5. > 50 mSv		

(1) Time of medical examination	(2) Work process change	(3) Handling volume/frequency
1. Employment 2. Transfer 3. Periodical 4. Resignation 9. Other	1. Yes 2. No 3. Not sure 9. Other	1. Increased 2. Decreased 3. Unchanged 4. Not sure 9. Other
(4) Local exhaust ventilation	**(5) Use of protective equipment**	**(6) Type of protective equipment**
1. Always used 2. Sometimes used 3. Not installed 9. Other	1. Always used 2. Sometimes used 3. Not used 9. Other	1. Protective caps (helmet) 2. Protective glasses 3. Protective masks 4. Protective gloves 5. Protective creams 6. Protective clothing 7. Safety boots 8. Ear protectors 9. Other
(7) Accidental massive exposure		
1. Yes 2. No 3. Not sure 9. Other		

Do not cut here.

General Incorporated Foundatior
Medical Information Health Foundation Health Renaissance - Self-reformation is the first step to health -

Special Medical Examination Form

健康寿命をのばそう!
Smart Life Project

Postcode 812-0025 Koshin Bldg 4F, 4-15, Tenyamachi, Hakata-ku, Fukuoka
<Head office> TEL (092) 272-2391 <Contact> TEL (092) 271-6421

Office name / Affiliation: This is an example of a stylistic translation of a word, so don't write directly

Name

<Employee No.>
<Other information>

List of work codes

O Organic solvents	L Lead	I Ionizing radiation
001 Production of organic solvents	001 Roasting, sintering, or melting in the processes of smelting or refining	010 Medical X-ray apparatus
002 Production of medicines	002 Melting in the processes of smelting or refining copper/zinc	011 Industrial X-ray apparatus for imaging
003 Printing	003 Processes of manufacturing, repairing or disassembling lead batteries or their parts	012 Industrial X-ray apparatus for fluoroscopy
004 Drawing	004 Melting lead, encasing things in lead or stripping things of lead during the manufacturing process of electric wires or cables	013 Industrial X-ray apparatus for analysis
005 Polishing/waterproofing	005 Manufacturing lead alloys, or manufacturing, repairing or disassembling products of lead	014 Industrial X-ray apparatus for other purposes
006 Adhesive application	or lead alloys	015 Charged particle accelerator
007 Bonding	006 Melting, casting, pulverizing, mixing,	016 X-ray tubes in the manufacturing process
008 Washing/wiping	agitating for air-cooling, sieving, calcining, firing,	017 Kenotron in the manufacturing process
009 Painting	drying, carrying, feeding or taking out from a container during the manufacturing process of lead compounds	018 Medical γ-ray irradiation apparatus
010 Drying	007 Lining things with lead	019 Industrial γ-ray irradiation apparatus
011 Experiment/research	008 Crushing, welding, thermal cutting, cutting, riveting, heating lead,	020 Equipped with radioisotopes other than γ-ray irradiation apparatus
012 Work inside a tank	or rolling materials lined with lead or coated with lead-containing lacquer	
	or removing lead-containing lacquer	021 Radioisotopes
T Tetraalkyl lead	009 Work inside lead equipment	022 Nuclear reactor
001 Production of leaded gasoline	010 Crushing, welding, thermal cutting, or cutting lead equipment	023 Radon gas in tunnels
002 Mix into gasoline	011 Dispersing or removing powdered-lead, etc. during the manufacturing process of transfer paper	
003 Repair of machines/equipment	012 Melting, casting, pulverizing, mixing, sieving, encasing things in lead or stripping things of lead	
004 Work inside a tank	during the manufacturing process of lead compounds	**A Asbestos**
005 Disposal of residues	013 Soldering things in places where natural ventilation is insufficient	001 Amosite
006 Handling containers	014 Glazing things with a glaze containing lead compounds or firing things glazed with	Manufacture and handling (> 0.1% of weight)
007 Research	that glaze	002 Crocidolite
008 Decontamination	015 Decorating things with paints containing lead compounds, or firing things decorated with	Manufacture and handling (> 0.1% of weight)
	that paint	010 Asbestos (excluding amosite and crocidolite)
H High pressure	016 Hardening or tempering metals using molten lead furnace, or	Manufacture and handling (> 0.1% of weight)
010 Work in pressurized chamber (caisson)	sand-bathing those metals	020 Asbestos (excluding Code 001, 002, and 010)
020 Diving	017 Picking type, typesetting or taking type into pieces in the power-using printing process	Manufacture and handling (> 0.1% of weight)
	018 Cleaning at workshops where the work listed in each of the preceding items (excluding 009) is carried out	

Notes

● Fill in the bold-framed area on pages **2 and 4** only with a **pencil (B or harder if possible)**.

● If your name, date of birth, etc. are printed in advance, check and correct errors, if any, with a pencil.

● This form is processed mechanically. Do not fold or bend anywhere other than the perforated line.

★ See **back side of the Instruction to Fill Out Special Medical Examination OCR for the work code** of **pneumoconiosis**.

Special

Container for ⇒ Urine sediment | urinalysis | Metabolite

● Past medical history

Be sure to check the box of "N/A" in the past history if you have no medical history. Check the box of the disease name if you have current or past medical history.

Disease name	Under treatment	Past history	Disease name	Under treatment	Past history
→					

● Smoking	Yes	No	Quit
Current regular smoker			
No. of cigarettes smoked (Yes/Quit) →			/Day
Period (Yes/Quit) →			Year(s)

* Regular smoker means "those who have so far smoked ≥

Check "Quit" if you have quit smoking recently and have not smoked for 1 month.

● Alcohol	Enter numerical value.
Frequency	1. Every day 2. Sometimes 3. None
Amount per day	1. < 1 go 2. 1 - < 2 go 3. 2 - < 3 go 4. ≥ 4 go
Amount equivalent to 1 go (180 mL) of sake Medium bottle of beer×1 (500 mL) Distilled spirits of 25° (110 mL) Whisky double (60 mL) Two glasses of wine (240 mL)	(Every day/Sometimes) ↑

● Subjective/objective symptoms

Be sure to check the box of "N/A" if you have no subjective symptoms. Check the box of the symptom(s) if you have subjective symptom(s). [box] is for physician to check objective symptoms.

Symptoms	Subjective (Examinee)	Objective (Physician)	Symptoms	Subjective (Examinee)	Objective (Physician)	Symptoms	Subjective (Examinee)	Objective (Physician)
→								

--- *Cautions regarding physician's comment ---
(1) If there is no objective symptoms in the list, be sure to check "N/A".
(2) Add only symptoms considered to be caused by the special work.
(3) Write clearly for import of data into the computer system.
(4) Be sure to write the physician's name (seal) even if you do not have comments.
(5) Objective symptoms with asterisk (*) especially require careful observation.

● Physician's comment (symptoms caused by the special work)

★ Pneumoconiosis Difficulty breathing I / II / III / IV / V

◆ Asbestos

Physician's name

★ Pneumoconiosis interview is colored for physicians to easily understand.

Do not cut here.

901 Special medical examination form

Name of health insurance	
Organization name (Office name)	
Name	Sex / Age years

Date of examination	2 0	◆ Asbestos ★ Pneumoconiosis
Control No.		
Organization		Site

Department					
Employee No.		Date of employment		Examinee No.	

Blood	Finished	ID No.	← ID required at metabolite collection
Grip strength	1st	Right .	Left .

Visual acuity	Right uncorrected	Left uncorrected	Right (corrected)	Left (corrected)
Far point	.	.	.	.

Hearing (threshold)	Right	Left
250 Hz (dB)		
500 Hz (dB)		
1000 Hz (dB)		
2000 Hz (dB)		
4000 Hz (dB)		
6000 Hz (dB)		
8000 Hz (dB)		

Hearing (screening) [1. No findings 2. Findings]			
1000 Hz (Screening)			
30 db findings Right		30 db findings Left	
4000 Hz (Screening)			
25db findings Right		25db findings Left	
30 db findings Right		30 db findings Left	
Urobilinogen			

This is an example of a stylistic translation of a word, so don't write directly

Urinalysis	Occult blood		Protein		Glucose	

Blood pressure 1	Systolic	-	Diastolic	
Blood pressure 2	Systolic	-	Diastolic	

◆ Asbestos
★Pneumoconiosis imaging conditions
KV
mAs
Intensifying screen .

Chest X-ray	Indirect	Direct	Film No.

Pulmonary function test			
Predicted vital capacity (VCP)	.	Vital capacity (VC)	.
Vital capacity percentage (%VC)	.	Forced expiratory volume in 1 second (FEV1)	.
forced expiratory volume in 1 second as percent of FVC (FEV1%)	.		

Dental				
Examination findings	No findings	Findings	Physician's name	Write your full name.
Detailed findings				

Metabolite		Fundus	Right		Left	
Sediment		Eardrum	Normal		Abnormal	
		Limb motor function	Normal		Abnormal	

[Urinalysis result] 1 : (-) 2 : (±) 3 : (+) 4 : (2+) 5 : (3+)

Enter "/" if cancelled.

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Check to cancel examination. For entry by medical staff.

Basic examination items

Note This translation is just for reference purposes. Your answers must be entered on the original Japanese form.

Note Please fill in with a ballpoint pen.

Medical

	medical history	Under treatmen	Past history
00	no history →		
10	Hypertension		
11	Heart disease		
12	Liver disease		
13	Diabetes		
14	Dyslipidemia		
15	Gout		
16	Anemia		
17	Gastric or duodenal ulcer		
18	Kidney disease		
20	pulmonary tuberculosis		
21	Pleuritis		
22	bronchitis		
23	Bronchiectasis		
24	Bronchial asthma		
25	Emphysema		
40	conjunctivitis		
41	Keratitis		
42	Cataract		
43	Retinitis		
54	Neuralgia		
55	Lower back pain		
60	Dermatitis		
61	Otitis media		
70	Meniere's disease		
71	Autonomic imbalance		
73	Parkinson's syndrome		
85	Organic solvent poisoning		
86	Chemical addiction		
88	Asbestosis		

○smoking	Yes	No	quited
Currently,do you			
Number of cigarettes per day			day
Number of years			Years

(※ Regular smoking is defined as having smoked during the last one month and either having smoked at least 100 cigarettes since starting or having smoked for at least 6 months)

If you recently quit smoking and have not smoked for at least the past one month,check"No"

○Drink liquor	Enter the appropriate number below.
Frequency	1. Every day 2. Sometimes 3. No drink
Glasses per day	1.Less than one 2.One or more but less than two 3.Two or more but less than three 4.Three or more

One glass equivalents:
180 ml of sake
500 ml (1 can) of beer
110ml of shochu (35%)

○Subjective symptoms

	○Symptoms	Awareness (person himself)	doctor
000	no symptoms →		
100	Headache		
101			
102	**Dizziness or dizzy after standing**		
151	Vision loss		
153	Eye strain / pain		
202	The inside of my nose is tingling		
252	My throat is		
300	Skin irritation		
302	The skin turns red		
304	There is a crush on the skin		
355	Palpitations or shortness of breath		
400	I feel nauseous		
401	Vomiting what you ate		
402	Appetite loss		
404	I have a stomachache		
502	Hands, fingers and arms tremble		
503	Numbness		
504	My fingers and arms		
506	Numbness in the legs,waist		
507	I have a pain in my legs,waist		
508	Grip strength has weakened		
550	Weight loss		
551	Sleep disorder		
552	I feel uneasy		
553	get annoyed		
554	Lack of concentration		
182	*Lens turbidity		
303	*Dry skin		
305	*Abnormal nails		
821	*Abnormal patellar tendon reflex		
822	*Abnormal Achilles tendon reflex		

This is the doctor's objective entry field.

This is a doctor's entry field, please do not fill in anything.

--- ※診察医師コメントについての注意事項 ---
① 表記リストに他覚が無い場合 必ず『特になし』にチェック
② 特殊業務起因と考えられる症状のみ追加で記入
③ システム取込の為、綺麗な文字でお願いします
④ コメントのない場合でも必ず医師名(印鑑)を記入
⑤ * の付いた症状は特に他覚重視になります

● 診察医師コメント (特殊業務起因)

医師名