

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: _____ 年齢 Age: _____
 Family name, First name Middle name 女 Female

1. 身体検査
 Physical Examinations

- (1) 身長 Height _____ cm 体重 Weight _____ kg
- (2) 血圧 Blood pressure _____ mm/Hg ~ _____ mm/Hg 血液型 Blood Type

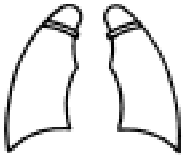
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 RH

+
-

 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
- (4) 聴力 Hearing: 正常 normal _____ 異常 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 applicant's chest x-ray (X-ray taken more than 6 months prior to the certification is NOT valid).



肺 lung: 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 lung.

3. 現在治療中の病気 Disease Treated at Present: Yes (Disease: _____) No

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

Tuberculosis..... (. . .) Malaria..... (. . .) Other communicable disease..... (. . .)
 Epilepsy..... (. . .) Kidney Disease..... (. . .) Heart Diseases..... (. . .)
 Diabetes..... (. . .) Drug Allergy..... (. . .) Psychosis..... (. . .)
 Functional Disorder in extremities..... (. . .)

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。
 Please describe your impression.

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せんか?
 In view of the applicant's history and the above findings, is it your observation 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: _____