

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: _____, _____, _____
Family name, First name Middle name
男 Male 生年月日 Date of Birth: _____
女 Female

1. 身体検査

Physical Examination

(1) 身長 _____ cm 体重 _____ kg
Height Weight

(2) 血圧 _____ mm/Hg~ _____ mm/Hg 血液型 Blood Ty

A	B	O
RH	+	-

 脈拍 整 Regular
不整 Irregular
Pulse

(3) 視力 Eyesight: (R) _____ (L) _____
裸眼 Without glasses 矯正 With glasses or contact lenses
色覚異常の有無 正常 Normal
異常 Impaired
Color blindness

(4) 聴力 正常 Normal 低下 Impaired
Hearing: 言語 正常 Normal
Speech: 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 the applicant's chest X-rays (X-rays taken more than six months prior to the certification are NOT valid).



肺 正常 Normal
Lungs: 異常 Impaired

心臓 正常 Normal
Cardiomegaly: 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 lungs.

3. 現在治療中の病気 Yes (Disease _____)
Disease currently being treated No

4. 既往症

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

(If the applicant has not contracted any of the disease, please check "None".)(いずれも該当しない場合は、なしにチェックすること。)

Tuberculosis..... (. .) Malaria..... (. .) Other communicable disease..... (. .)

Epilepsy..... (. .) Kidney disease..... (. .) Heart disease..... (. .)

Diabetes..... (. .) Drug allergy..... (. .) Psychosis..... (. .)

Functional disorder in extremities..... (. .)

None.....

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。(問題がない場合も、その旨ご記入ください。)

Please give your impression of the applicant's health. (If you do not have a particular opinion, please write as such.)

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えますか？

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