Medical Examination Report

健康診断書

To be filled by a medical practitioner

Name ______________________ Gender ___Male / Female___

Date of Birth
(year / month / date) ______________________ TEL: ______________

Home Address

BASIC DATA

Height / 身長 ________ cm Weight / 体重 ________ kg

Eyesight / 視力

Without glasses/ 裸眼	Left / 左		Hearing / 聴力	Left / 左	
	Right / 右			Right / 右	
With glasses / 矯正	Left / 左				
	Right / 右				

MEDICAL HISTORY (if any, indicate the age of contraction):

Tuberculosis / 結核	〔 〕	Age	Malaria / マラリア	〔 〕	Age
Epileasy / てんかん	〔 〕	Age	Kidney disease / 腎疾患	〔 〕	Age
Diabetes / 糖尿病	〔 〕	Age	Allergy / アレルギー	〔 〕	Age
Rheumatic fever / リューマチ熱	〔 〕	Age	Heart desease / 心疾患	〔 〕	Age
Other contagious disease	〔 〕	Age			

Comments

PRESENT MEDICAL PROBLEMS (Please note any illness)

Tonsil, nose or throat / 扁桃腺・鼻・咽喉	〔
Stomach or digestive system / 胃・消化器系	〔
Brain or nervous system / 脳・内臓器官	〔
Heart or circulatory system / 心臓・血管系	〔
Gento-urinary system / 泌尿生殖器系	〔
Blood or endocrine system / 血液・内分泌器官	〔
Skin / 皮膚	〔
Other internal organs / その他の内臓器官	〔

CHEST X-RAY EXAMINATION (The x-ray result is valid only for 6 months form the day of examination)

Normal / 健康 〔 〕

To be rechecked / 要観察 〔 〕

Requires medical treatment / 要医療 〔 〕

Describe the finding of the Chest X-ray / 所見

Date of examination ____________

TEST FOR HIV

Positive / 陽性〔 〕 Negative / 陰性〔 〕 Interminate /未確定〔 〕

Screening Test / スクリーニング検査

EIA 〔 〕 Serodia 〔 〕 Others ____________

Confirmatory Test / 確認 Western Blot 〔

Any other remarks

I hereby certify the accuracy of the above diagnosis.

Physician's Signature /医師の 署名: ____________

Physician's Name / 医師の氏名: ____________

Institution / 検査施設名: ____________

Physician's Address / 住所: ____________

Date/診断年月日:
(year / month / date) ____________

Stamp of Institution