

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 Type

A	B	O
RH	+	-

 脈拍 Pulse 整 Regular
不整 Irregular

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

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



肺 Lungs: 正常 Normal
異常 Impaired
Date _____
Film No. _____

心臓 Cardiomegaly: 正常 Normal
異常 Impaired
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 Disease currently being treated Yes (Disease _____)
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われますか？
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: _____