

# 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 

A B O	RH	+
		-

 脈拍 Pulse 整 regular 不整 irregular

(3) 視力 Eyesight: (R) \_\_\_\_\_ (L) \_\_\_\_\_ 色覚異常の有無 color blindness 正常 normal 異常 impaired  
裸眼 without glasses

(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 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

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すか？  
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: \_\_\_\_\_

The following questions are completed by the physician.

(1) Has the participant previously been hospitalized? Yes  No   
If yes, when and for what reason.

(2) Will the participant require any ongoing medication or treatment  
for any particular condition during the program? Yes  No   
If yes, explain.

(3) Any previous nervous or eating disorders? Yes  No   
If yes, explain.

(4) Any physical limitations that could prevent them from normal  
activities such as sports, etc. Yes  No   
If yes, explain.