

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

1. 身体検査
Physical Examinations

(1) 身長 _____ cm 体重 _____ kg
Height Weight

(2) 血圧 _____ mm/Hg ~ _____ mm/Hg 血液型

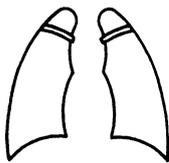
ABO	RH	+
		-

 脈拍 整 regular
Blood pressure Blood Type Pulse 不整 irregular

(3) 視力 Eyesight: (R) _____ (L) _____ (R) _____ (L) _____
裸眼 without glasses 矯正 with glasses or contact lenses 色覚異常の有無 正常 normal
色覚異常の有無 異常 impaired
color blindness

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



肺 正常 normal 異常 impaired
lung: 正常 normal 異常 impaired
← Date _____
Film No. _____

心臓 正常 normal 異常 impaired
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 Yes (Disease: _____) No
Disease Treated at Present

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
Hemoglobin: _____ gm/dl, GPT: _____ anemia

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えますか？
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?

日付 _____ 署名 _____
Date: _____ Signature: _____
yes no

医師氏名
Physician's Name in Print: _____

検査施設名
Office/Institution: _____
所在地
Address: _____