検診受診票(英語)

Medical checkup sheet

Bring this sheet with the questionnaire sheet of the screening on the checkup day.

Date of checkup Year Month Day

団体名 (会社又は市町村名)	
Name (Furigana)	
Kanji	
Sex	
Zip Code	-
Telephone (For daytime)	- -
Address	

受診No.

職員No. (住民)

Request for your understanding on handling personal information

Based on the foundation's personal information protection policy, the foundation will make sure to manage security and properly handle personal information which is acquired through respective medical checkup projects.

1. Personal information of the person taking medical checkup including the medical checkup results is used for the following purpose.
   ① Preparation such as medical checkup reservation and material making, medical checkup implementation, result report, health guidance, and data management on medical checkup record
   ② Clerical work for examination fee・accounting
   ③ Enhancing precision of the foundation's medical checkup work, research analysis for improvement, management of detailed examination, follow-up examination etc.
   ④ Academic research, medical statistics, report to institutions (The information is used in unidentifiable form.)
   ⑤ Reply to questions, information on the next medical checkup

2. Medical checkup results etc. are provided on the regulated-by-law basis to medical checkup organizers (companies・municipalities・health insurance union etc.). Medical checkup organizers are obligated to manage personal information properly by contract etc., and personal information of the person taking medical checkup is strictly protected by law at medical checkup organizers, too.

3. Although personal information is handled in the foundation, partial data processing and interpretations of radiograms may be committed to the companies which exchanged contract with the foundation on personal information protection, or the doctors with expertise. The foundation supervises the commissioned organizations on safe management of personal information.

4. Personal information is not acquired from third party, but name list etc. of the persons taking medical checkup may be acquired from medical checkup organizers.

5. Regarding getting results of detailed examination, by getting results of the detailed examination of the person whose abnormality was found through the medical checkup this time (cancer screening), precision (correctness) of the examination and the screening are enhanced, and you can have better examination and screening.

6. Regarding medical checkup results whose items are out of the legal scope, they are also provided (reported) to the medical checkup organizer as result report. If you cannot agree with this, having individual medical checkup is recommended. However, as afore-mentioned phrases, personal information of the person taking medical checkup is strictly protected by law at medical checkup organizer, too.

7. As for personal information of the person taking medical checkup, the person itself can request notification or disclosure on the purpose of use to the foundation. As a result of disclosure, if the relevant information is not correct, the person can request its correction, addition, or deletion. Regarding personal information of the person taking medical checkup, the person can request halt of use or deletion.
Please contact the following counters.
In the case, the person's identity is confirmed to make sure the person is the one taking the medical checkup, or a legal representative.

【Contact for all matters regarding personal information protection, complaints, and consultation】
General Incorporated Foundation Nagoya Public Medical Research Institute (Nagoya Koshu Igaku Kenkyujo)
Address: 〒453-8521 Nagoya Shi, Nakamura Ku, Nagaosa Cho 4-23
Personal Information Protection Management: Operation Department Manager (in charge)
Personal Information Protection Consultation Counter: Management Department Manager (in charge)
Tel: (052) 412-3111 (main phone nr.) E-mail: privacy@meikoui.or.jp

※Please have a medical checkup after agreeing with above-written "Request for your understanding on handling personal information".

☐ I agree. ☐ I do not agree. Name(Signature)

Medical checkup is not available without your agreement.

Thoracic X ray（Lung cancer）

※【Note】Make sure to read this.

1. When having a thoracic X ray, please wear a T shirt without buttons, fasteners, metallic objects, printed pictures or patterns. Please take off necklace, cold compress etc.
2. If you use insulin pump, or continuous glucose monitoring, please consult with your doctor in advance whether you can have an X ray, and take the equipment off at home and have a screening on the screening day.
3. **Never have a screening if you are pregnant or have possibility of being pregnant.**

Questionnaire　Please reply to the following questions of respective items.

For female person only

Any possibility of pregnancy? ☐ No ☐ Yes **If "Yes", you cannot have an X ray.**

Have you ever had a lung cancer screening?

☐ No ☐ **This is 2nd time.** ☐ **This is 3rd or more.** ⇒ Previous screening ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇓

Previous screening ☐ No abnormality ☐ Observation necessary ☐ Detailed examination necessary（Remark：　　）

Have you ever had any diseases below?

☐ No ☐ Yes⇒ ☐ Tuberculosis ☐ Pleuritis ☐ Pneumonia ☐ Asthma ☐ Chronic obstructive pulmonary disorder（COPD） ☐ Pneumo-coniosis ☐ Other（　　）

Have you ever worked in the following industries?

☐ No ☐ Yes⇒ ☐ Manufacturing/processing asbestos products ☐ Ceramics ☐ Metal processing ☐ Workplace with lots of dust ☐ Other（　　） Period：☐☐ Yrs.

Do you have the following symptoms recently?

☐ No ☐ Yes⇒ ☐ Cough ☐ Phlegm Bloody phlegm (Within 6 months)→Take consultation at medical institution. ☐ Weight loss

Do you smoke?

☐ No ☐ I used to ☐ Yes ⇒ Daily：☐☐ Cigarettes ☐☐ Year(s) (In the past)（Still now）

Passive smoking ☐ No ☐ Yes Period：☐☐ Year(s).

Any of your parents and siblings had cancer?

☐ No ☐ Yes⇒ Which part? ☐ Lung ☐ Other（　　）

Stomach X ray（Stomach cancer）

※【Note】Make sure to read this.

1. You are asked to drink barium and have an X ray. Pregnant person, person with possibility of pregnancy, person with intestinal obstruction or intestinal volvulus in the past, person with swallowing disorder, and person allergic to barium (hives, breathing difficulty) cannot have a screening.
2. If you use insulin pump, or continuous glucose monitoring, please consult with your doctor in advance whether you can have an X ray, and take the equipment off at home and have a screening on the screening day.
3. Do not eat from 10:00 pm on the previous day until end of the screening. You can drink water until bedtime but please refrain from drinking alcohol. Until 2 hours prior to the screening, you can drink 200ml water or hot water.
4. Regarding the medicine for blood pressure and heart disease, please take them 2 hours prior to the screening with 200ml water or hot water. Do not use medicine for diabetes, and insulin before the screening. About other medicines for internal use, please follow your doctor's instructions.

Questionnaire Please reply to the following questions of respective items.

For female person only

Any possibility of pregnancy now? ☐ No ☐ Yes ⇒ **If "Yes", you cannot have a stomach cancer screening.**

Have you ever had allergic reaction to the test with barium?

☐ No ☐ Yes ⇒ If "Yes", you cannot have a stomach cancer screening.

Have you ever had a stomach cancer screening?

☐ No ☐ **This is 2nd time.** ☐ **This is 3rd or more.** ⇒ Previous screening ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇓

Previous screening ☐ No abnormality ☐ Observation necessary ☐ Detailed examination necessary (Remark：　　)

Have you ever had any diseases below?

☐ No ☐ Yes⇒ ☐ Stomach ulcer ☐ Stomach polyp ☐ Duodenal ulcer ☐ Stomach inflammation ☐ Stomach cancer ☐ Other diseases of esophagus, stomach, duodenum (　　)

Have you ever had stomach/duodenum surgery? ☐ No ☐ Yes ☐ Heisei ☐ Reiwa ☐☐ Year Disease (　　)

Have you ever had treatment of removing Helicobacter pylori? ☐ No ☐ Yes ☐ Heisei ☐ Reiwa ☐☐ Year ☐ I do not know.

Do you have the following symptoms recently?

☐ No ☐ Yes ⇒ ☐ Stomach pain ☐ Heartburn ☐ Burps ☐ Nausea ☐ Food gets stuck ☐ Lack of appetite ☐ Consti-pation ☐ Diarrhea ☐ Bloody stool ☐ Weight loss

Luxury goods

Cigarettes ☐ I do not smoke. ☐ I used to smoke. ☐ I smoke. ⇒ Daily：☐☐ Ciga-rettes ☐☐ Year(s) (In the past) (Still now)

Alcohol ☐ I do not drink. ☐ Stopped. ☐☐ Year(s) ago ☐ Every day (5 days or more/week) ☐ Sometimes (1-4 days/week) ☐ Once in a while (1-3 days/month)

Any of your family members (blood relatives) had cancer?

☐ No ☐ Yes ⇒ ☐ Father ☐ Mother ☐ Siblings ☐ Grandparents

Colorectal cancer screening

※【Note】Make sure to read this.

1. Please avoid taking stool sample during menstruation.
2. If you had a biopsy with stomach endoscopy, take stool sample about 1 week later from the test.
3. Please take stool sample when you do not have white stool any more which you have right after stomach X ray (test with barium).

Questionnaire Please reply to the following questions of respective items.

Have you ever had a colorectal cancer screening?

☐ No ☐ **This is 2nd time.** ☐ **This is 3rd or more.**

Previous screening ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇓

Previous screening ☐ No abnormality・Negative・(－)

☐ With remark・Positive・(＋) ⇒ Did you have a detailed examination? ☐ No ☐ Yes ⇒ Result ☐ No abnormality ☐ With remark(　　)

Have you ever had any diseases below?

Disease of esophagus	☐ No	☐ Cancer	☐ Ulcer	☐ Polyp	☐ Other	
Disease of stomach/duodenum	☐ No	☐ Cancer	☐ Ulcer	☐ Polyp	☐ Other	
Disease of large intestine	☐ No	☐ Cancer	☐ Ulcer	☐ Polyp	☐ Colitis	☐ Other
Anal disease	☐ No	☐ Blind piles	☐ Bleeding piles	☐ Anal fistula	☐ Anal prolapse	☐ Other

Do you use any medicine regularly? ☐ No ☐ Yes（Name of the medicine　　）

Do you have the following symptoms recently? ☐ No ☐ Yes ☐ Constipation ☐ Diarrhea ☐ Bloody stool

What kind of food do you like? ☐ Meat ☐ Fish ☐ Vegetables ☐ Other（　　）

Luxury goods

Cigarettes ☐ I do not smoke. ☐ I used to smoke. ☐ I smoke. ⇒ Daily：☐☐ Ciga-rettes ☐☐ Year(s) (In the past) (Still now)

Alcohol ☐ I do not drink. ☐ Stopped. ☐☐ Year(s) ago ☐ Every day（5 days or more/week） ☐ Sometimes (1-4 days/week) ☐ Once in a while（1-3 days/month）

Any of your family members (blood relatives) had cancer?

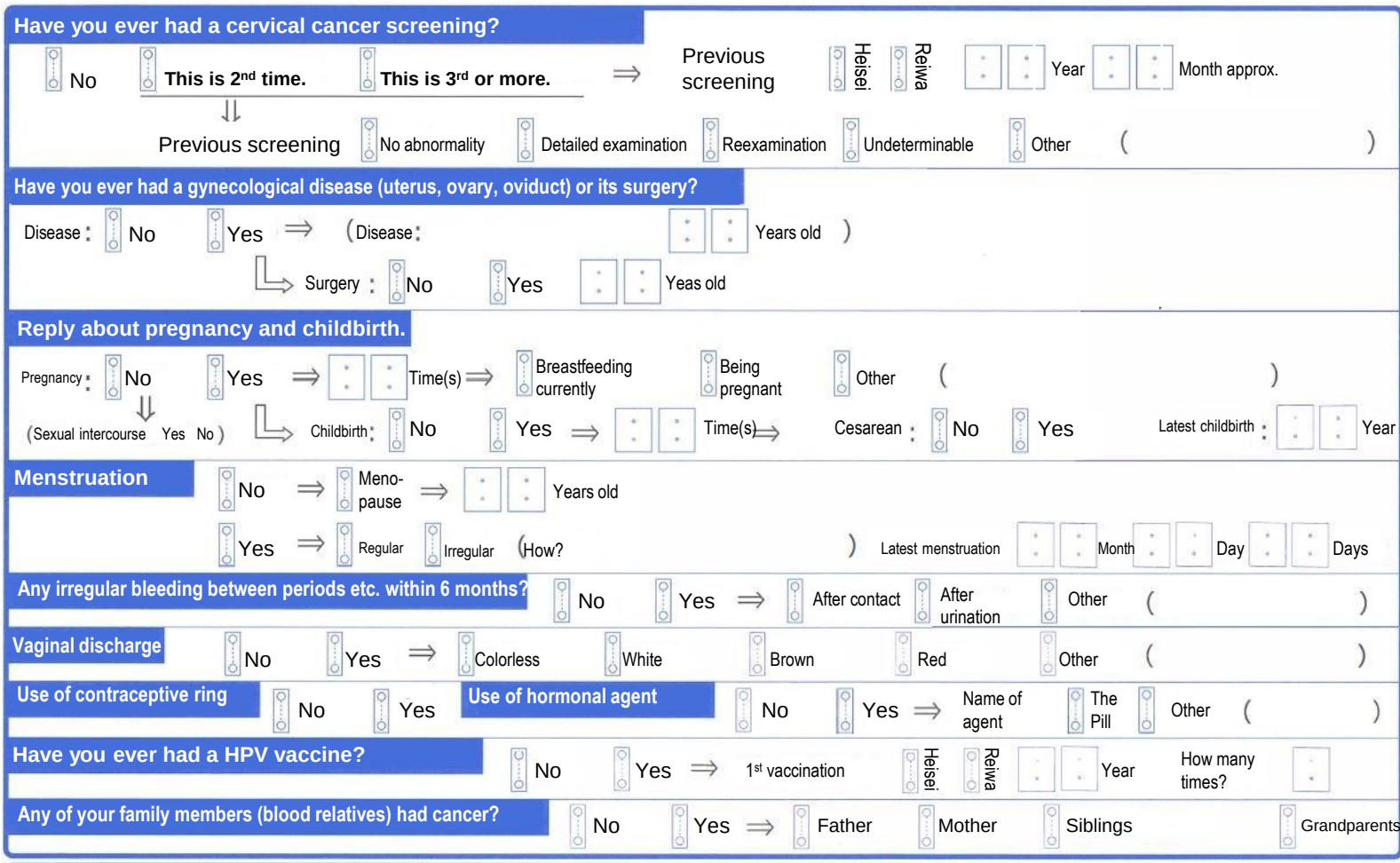
☐ No ☐ Yes ⇒ ☐ Father ☐ Mother ☐ Siblings ☐ Grandparents

Cervical cancer screening

※【Note】Make sure to read this.

1. Doctor's inspection and biopsy of cervix are implemented. Person who had surgery of complete cervix removal cannot have a screening.
2. Cervical cancer screening is not available during menstruation. Please change the date.

Questionnaire Please reply to the following questions of respective items.



Breast cancer screening

※【Note】Make sure to read this.

1. Person who cannot have a mammography test
   Person being pregnant or with possibility of pregnancy, breastfeeding person, person under 6 months after having stopped breastfeeding, person with pacemaker, CV Port (implantable type), or V-P Shunt (decompression shunt), person who had breast enlargement surgery
2. For mammography, If you use insulin pump, or continuous glucose monitoring, please consult with your doctor in advance whether you can have an X ray, and take the equipment off at home and have a screening on the screening day.
3. For echo test, breastfeeding person or person under 6 months after having stopped breastfeeding may not have precise results (Lesion is not shown on the image) depending on the condition of mammary glands. Please have a screening after 6 months of having stopped breastfeeding.
4. If you are aware of any symptoms, please do not have a screening, but go to a medical institution specialized with mammary glands

Questionnaire　Please reply to the following questions of respective items.

Please reply after reading above-written note.

Any possibility of pregnancy currently? ☐ No ☐ Yes ⇒ Gestational week ： ☐☐ Weeks Latest menstruation ： Reiwa ☐☐ Year ☐☐ Month ☐☐ Day

Did you have breast enlargement surgery? ☐ No ☐ Yes ⇒ ☐ Bag insertion ☐ Other injection

Do you use a pacemaker, CV Port (implantable type), or V-P Shunt? ☐ No ☐ Yes

If "Yes" in any of the cases, you cannot have a mammography test.

Have you ever had a breast cancer screening?

☐ No ☐ **This is 2nd time.** ☐ **This is 3rd or more.** ⇒ Previous screening ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇓

Previous screening ☐ Inspection Palpation ☐ Echo ☐ Mammography

The result（Not limiting the previous screening） ☐ Inspection Palpation ☐ It has been said that detailed examination is necessary. ⇒ ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇓

Result of the detailed examination ☐ No abnormality ☐ Cyst ☐ Fibroadenoma ☐ Mastopathy ☐ Other（　　）

Have you ever had a breast disease?

Breast disease： ☐ No ☐ Yes ⇒ （Disease ：　　）

Breast incision： ☐ No ☐ Yes

Hormone therapy： ☐ No ☐ Yes ⇒ Continues. ☐☐ Year(s)　I had it before for ☐☐ year(s), but not now.

Any of your family members (blood relatives) had cancer?

Breast cancer ☐ No ☐ Yes ⇒ ☐ Mother ☐ Older sister ☐ Younger sister ☐ Grandmother ☐ Aunt

Other cancer ☐ No ☐ Yes ⇒ ☐ Father ☐ Mother ☐ Siblings ☐ Grandparents

Menstruation

☐ No ⇒ ☐ Meno-pause ⇒ ☐☐ Years old

☐ Yes ⇒ ☐ Regular ☐ Irregular　Latest menstruation ☐☐ Month ☐☐ Day ☐☐ Days

Any abnormality with your breast currently?

〔Right〕 ☐ No ☐ Yes ⇒ ☐ Lump ☐ Deformity ☐ Bloody secretion ☐ Pain ☐ Other（　　）

〔Left〕 ☐ No ☐ Yes ⇒ ☐ Lump ☐ Deformity ☐ Bloody secretion ☐ Pain ☐ Other（　　）

Do you palpate yourself?

☐ No ☐ Sometimes ☐ Periodically (every moth)

Breastfeeding history

☐ No ☐ Yes ⇒ ☐ 6 months - under 1 year after having stopped breastfeeding ☐ 1 year or more after having stopped breastfeeding

Prostate cancer screening

※【Note】Make sure to read this.

1. Blood test is conducted to check prostate-specific antigen (PSA) in the blood. There is no diet limitation.

Questionnaire Please reply to the following questions of respective items.

Have you ever had a prostate cancer screening?

☐ No ☐ **This is 2nd time.** ☐ **This is 3rd or more.** ⇒ Previous screening ☐ Heisei ☐ Reiwa ☐☐ Year ☐☐ Month approx.

⇩ Previous screening

☐ No abnormality

☐ Detailed examination necessary ⇒ Did you have a detailed examination?

☐ No

☐ Yes ⇒ Result ☐ No abnormality ☐ With remark ( )

Have you ever had a prostate gland disease?

☐ No ☐ Yes ⇒ ☐ Benign prostatic hyperplasia ☐ Prostatitis ☐ Prostate cancer ☐ Other ( )

Do you have the following symptoms recently?

Do you feel pain when you urinate?	☐ No	☐ Yes
Do you feel heavy in perineal or anal area?	☐ No	☐ Yes
Do you have occasions to have pain in the waist or thigh (lower limb)?	☐ No	☐ Yes

Urination

☐ Good (It comes out well) ☐ Not satisfactory (Not bothering, but not as in the younger age) ☐ Not good (It does not come out well, taking time to finish)

How many times do you go to toilet from going to bed to getting up in the morning? ☐ Rarely ☐ Once or twice ☐ 3 times or more

Please fill in about your dietary life and luxury goods.

Cigarettes	☐ 20 or more/day	☐ Under 20/day	☐ I used to smoke	☐ I do not smoke
Alcohol	☐ Every day	☐ 2-3 times/week	☐ 2-3 times/month	☐ I do not drink
Rice	☐ 3 meals	☐ 2 meals	☐ 1 meal	☐ 2-3 times/week ☐ I do not eat
Meat	☐ Every day	☐ 2-3 times/week	☐ 2-3 times/month	☐ I do not eat
Vegetables	☐ Every day	☐ 2-3 times/week	☐ 2-3 times/month	☐ I do not eat
Seafood	☐ Every day	☐ 2-3 times/week	☐ 2-3 times/month	☐ I do not eat
Japanese tea	☐ 10 cups or more/day	☐ 5-9 cups/day	☐ 1-4 cups/day	☐ I do not drink

Osteoporosis screening

※【Note】Make sure to read this.

1. Heel is examined by ultrasound. Please come with footwear, easy to take off socks etc.

Questionnaire Please reply to the following questions of respective items.

Have you ever had any diseases below?

No / Yes ⇒ Thyroid gland / Parathyroid gland / Kidney disease / High blood pressure / Liver disease / Gastrointestinal / Gynecological / Other ( )

Have you ever broken bones?

No / Yes ⇒ Which part? Arm / Finger / Leg / Feet / Other ( )

Cause Traffic accident / During sport activity / Other ( )

Have you ever been on a diet?

No / Yes ⇒ How many times? : Time(s) . kg loss

Do you exercise regularly?

No / Yes ⇒ . Hour(s) / Exercise How often ? : Time(s) / Week . Year(s) (What exercise? :)

How long do you walk/sleep?

I walk daily about . hour(s) I sleep daily about . hours

Please fill in about your dietary life.

	Every day	3-6 times/week	Once or twice /week	Rarely		Every day	3-6 times/week	Once or twice/week	Rarely
Milk					Small fish which can be eaten whole				
Dairy products					Seafood				
Tofu/Soybean products					Green and yellow vegetables				
Meat									

For female person only

Menstruation / Regular / Irregular / Menopause / Being pregnant

Medical checkup sheet

Questionnaire Please reply to the following questions of respective items.

① Have you ever had a medical checkup?

☐ Every year ☐ Sometimes ☐ First time

② Medicinal history(Obligatory)

※Make sure to fill in.

- ☐ Yes ☐ No Medicine to lower blood pressure
- ☐ Yes ☐ No Medicine to lower blood sugar level / Insulin injection
- ☐ Yes ☐ No Medicine to decrease cholesterol or neutral fat

③ Currently or in the past, do (did) you have the following diseases?

☐ No																			
☐ Heart disease	☐ In treatment	☐ Before	☐ Dyslipidemia	☐ In treatment	☐ Before	☐ Tuberculosis	☐ In treatment	☐ Before	☐ Stomach inflammation	☐ In treatment	☐ Before	☐ Hemorrhoids	☐ In treatment	☐ Before	☐ Ear disease				
☐ High blood pressure	☐ In treatment	☐ Before	☐ Liver disease	☐ In treatment	☐ Before	☐ Asthma	☐ In treatment	☐ Before	☐ Stomach polyp	☐ In treatment	☐ Before	☐ Anemia	☐ In treatment	☐ Before	☐ Eye disease				
☐ Cerebro-vascular disorder	☐ In treatment	☐ Before	☐ Pancreatic disease	☐ In treatment	☐ Before	☐ Pneumonia	☐ In treatment	☐ Before	☐ Duodenal ulcer	☐ In treatment	☐ Before	☐ Gynecological disease	☐ In treatment	☐ Before	☐ Osteoporosis				
☐ Diabetes	☐ In treatment	☐ Before	☐ Kidney disease	☐ In treatment	☐ Before	☐ Pneumo-coniosis	☐ In treatment	☐ Before	☐ Esophageal disease	☐ In treatment	☐ Before	☐ Mammary gland disease	☐ In treatment	☐ Before	☐ Cancer				
			☐ Gout (Hyperuricemia)	☐ In treatment	☐ Before	☐ Stomach ulcer	☐ In treatment	☐ Before	☐ Large intestine disease	☐ In treatment	☐ Before	☐ Thyroid gland disease	☐ In treatment	☐ Before	☐ Other ( )				

④ Currently, are you aware of the symptoms on the right?

☐ No	☐ Severe fatigue	☐ Dizziness	☐ Cough / Phlegm	☐ Heartburn	☐ Stomach-ache	☐ Food gets stuck	☐ Constipation	☐ Diarrhea	☐ Have pins and needles on hands and feet
	☐ Headache	☐ Palpitations / Short of breath	☐ Irregular pulse	☐ Chest pain	☐ Vomit	☐ Lack of appetite	☐ Being thirsty	☐ Swollen body	☐ Other ( )

⑤ Do you have a smoking habit?

(※"Smoking habit" means, having smoked for a month recently, having smoked for 6 months or more in whole life, or having smoked 100 cigarettes or more in total.)
Including e-cigarettes

- ☐ No
- ☐ I smoked before, but did not smoke in the past 1 month.
- ☐ Yes → ☐☐☐ Cigarettes/day, ☐☐ Years

⑥ How often do you drink alcohol?

- ① Every day
- ② 5-6 days/week
- ③ 3-4days/week
- ④ Once or twice/week
- ⑤ 1-3 days/month
- ⑥ Less than 1 day/month
- ⑦ Stopped and not drinking 1 year or longer recently
- ⑧ I do not drink (I cannot drink)

How much /day?

In case of ① to ⑥, please fill in how much you drink.

- ① Under 180 ml
- ② 180-under 360 ml
- ③ 360-under 540 ml
- ④ 540-under 900 ml
- ⑤ 900 ml or more

⑦ Familial medical history

☐ No

	Heart disease	Stroke	High blood pressure	Diabetes	Hyper-lipidemia	Cancer
Parents						
Siblings						
Grand-parents						

⑧ Please fill in the following questionnaire, too.

- ☐ Yes ☐ No I had treatment of cerebrovascular disease.
- ☐ Yes ☐ No I had treatment for heart disease.
- ☐ Yes ☐ No I had treatment for chronic kidney failure.
- ☐ Yes ☐ No I was told by a doctor that I have anemia.
- ☐ Yes ☐ No I have gained weight by 10 kg or more since I was 20 years old
- ☐ Yes ☐ No I've done exercise to sweat lightly for 30 minutes or longer, 2 days/week or more, for 1 year or longer
- ☐ Yes ☐ No In daily life, I do physical activities equivalent to waking for 1 hour/day or more
- ☐ Yes ☐ No Compared to others in the same age and gender, I walk fast
- Condition of chewing food: ☐ Can chew anything ☐ Not easy to chew ☐ Cannot chew
- Compared to others, I eat fast: ☐ Fast ☐ Normal ☐ Slow
- ☐ Yes ☐ No I have dinner within 2 hours prior to bedtime 3 times or more/week
- ☐ Every day ☐ Sometimes ☐ Rarely I have snack or sweet drink other than 3 meals
- ☐ Yes ☐ No I do not eat breakfast 3 times or more/week
- ☐ Yes ☐ No I can take a rest sufficiently with sleep
- ☐ Yes ☐ No I have had special health guidance on life habit

Are you thinking of improving your life habit such as exercise and dietary life?

- ☐ I am not going to improve it
- ☐ I am going to improve it (Within 6 months)
- ☐ I am going to improve it soon (Within 1 month), I am improving it gradually
- ☐ I have already been improving it (Within 6 months)
- ☐ I have already been improving it (6 months or more)

※ Please have a medical checkup after agreeing with "Request for your understanding on handling personal information" on the other side.

☐ I agree ☐ I do not agree. Name(Signature)

Medical checkup is not available without your agreement.