

Examples

Entry spots (circle the most applicable items.)

Medical Questionnaire

[Kyoto City National Health Insurance
Specified Health Checkup]

Fill in every spot within the red frame. (Circle the applicable items.)

Date Year month day

Have you had any diseases until now?	<input checked="" type="radio"/> No <input type="radio"/> Yes	Hypertension, Diabetes, Dyslipidemia, Cerebral infarction, Cerebral hemorrhage, Heart Disease, Arrhythmia, Anemia, Liver disease, Kidney disease, Tuberculosis, Thyroid disease, Gastrointestinal disease, Depression, Osteoporosis, Orthopedic disease, other
Current diseases (being treated or being observed)	<input checked="" type="radio"/> No <input type="radio"/> Yes	Hypertension, Diabetes, Dyslipidemia, Cerebral infarction, Cerebral hemorrhage, Heart Disease, Arrhythmia, Anemia, Liver disease, Kidney disease, Tuberculosis, Thyroid disease, Gastrointestinal disease, Depression, Osteoporosis, Orthopedic disease, other
Describe your symptoms	<input type="radio"/> No <input checked="" type="radio"/> Yes	Chest pressure, heart palpitations, shortness of breath, stiff shoulders, lower back pain, knee pain, insomnia, numbness in the hands or feet, dizziness, <input checked="" type="radio"/> headaches, lightheadedness, tinnitus, diarrhea, constipation, bloating, feeling sick or other symptoms

No.	Questions	Answers (circle whichever applies)
1	Currently, are you using any of the following medicine or injection?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No <input type="radio"/> ① Yes <input checked="" type="radio"/> ② No <input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
2	a. medicine to lower blood pressure	
3	b. medicine to lower blood sugar or insulin injections (diabetes medicine)	
4	c. medicine to lower cholesterol or triglycerides etc.	
4	Have you ever been diagnosed with a stroke (cerebral hemorrhage or cerebral infarction), or been treated for the same?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
5	Have you ever been diagnosed with heart disease (angina pectoris, myocardial infarction etc.), or been treated for the same?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
6	Have you ever been diagnosed with chronic kidney disease or renal failure, or been treated for the same?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
7	Have you ever been diagnosed with anemia?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
8	Do you currently smoke regularly? [Definition 1: you have smoked within the last month. Definition 2: you have smoked for more than 6 months or more than 100 cigarettes in your life.]	<input checked="" type="radio"/> ① Yes [Definitions 1 and 2 apply] <input type="radio"/> ② I have smoked but not for a month or more [Only definition 2 applies] <input type="radio"/> ③ No [Neither definition 1 or 2 apply]
9	Have you gained more than 10 kg since you were 20 years old?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
10	Have you exercised to the point of light sweating for 30 minutes at least twice a week for at least 1 year?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
11	Do you walk or do equivalent physical activity for at least one hour every day?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
12	Do you walk faster than other people who are the same gender and roughly same age as you?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
13	Which of the following apply to you when you are eating?	<input checked="" type="radio"/> ① I can chew any type of food <input type="radio"/> ② My teeth, gums and alignment bother me so there are some things that are difficult to chew <input type="radio"/> ③ I cannot chew most things
14	Are you a faster eater than your peers?	<input checked="" type="radio"/> ① Fast <input type="radio"/> ② Normal <input type="radio"/> ③ Slow
15	Do you eat dinner within 2 hours before you sleep more than 3 times a week?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
16	Do you have snacks or sweet drinks between meals?	<input type="radio"/> ① Every day <input type="radio"/> ② Sometimes <input checked="" type="radio"/> ③ Almost never
17	Do you skip breakfast more than 3 times a week?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
18	How often do you drink alcohol? **"I quit" means that you used to have at least once a month but have not for the last 1 year or more.	<input type="radio"/> ① Every day <input checked="" type="radio"/> ② 5 to 6 days a week <input type="radio"/> ③ 3 to 4 days a week <input type="radio"/> ④ 1 to 2 days a week <input type="radio"/> ⑤ 1 to 3 days a month <input type="radio"/> ⑥ Less than 1 day a month <input type="radio"/> ⑦ I quit* <input type="radio"/> ⑧ I don't drink alcohol
19	Daily alcohol consumption amount [Definition: 1 drink can be considered 180 ml of 15% wine, 500 ml of 5% beer, 350 ml of 7% beer, 110 ml of 25% shochu, or 60 ml of 43% whiskey]	<input type="radio"/> ① Less than 1 drink <input type="radio"/> ② Between 1 and less than 2 drinks <input type="radio"/> ③ Between 2 and less than 3 drinks <input checked="" type="radio"/> ④ Between 3 and less than 4 drinks <input type="radio"/> ⑤ 5 drinks or more
20	Do you get enough rest through sleep?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
21	Are you trying to improve your lifestyle through exercise or changing your eating habits?	<input type="radio"/> ① I have no plan for changing my lifestyle <input type="radio"/> ② I plan to change my lifestyle (within the next 6 months) <input type="radio"/> ③ I plan to change my lifestyle soon (within the next month), and have already started making some changes <input type="radio"/> ④ I have already begun making changes (within the last 6 months) <input checked="" type="radio"/> ⑤ I have already begun making changes (for more than 6 months)
22	Have you ever received specific advice for how to change your lifestyle?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No

Notes for answering

•Please make sure that you write hard enough that the words copy on to the last page.

[If the words have not copied through well enough, please trace over your writing again.]

•If you are older than 75 at the time of consultation, you cannot use this form.

•It is necessary to enter your gender as medical examination criteria differ accordingly.

What to bring the day of your consultation

Insurance card, consultation card, medical questionnaire (this form), 500-yen consultation fee (only if you are under the age of 64).

For those receiving chest examinations: *You can only receive the examination at the same time at the group checkup venue on weekdays.

•You can keep your shirt on for the chest examination if it is a plain t-shirt.

•Before the examination you need to remove your bra, necklaces or anything affixed to your body.

〒 604-8091	Reference number	
Address 京都市中京区 寺町通御池下る下本能寺前町	Symbol 京	Number
500 番地 中信御池ビル 4 階	Insurance number	
Katakana	実施機関コード:	
Name 京都 太郎	実施機関の所在地、名称、電話番号	
Sex Male	医師氏名	
Date of Birth 1984年(year) 5月(month) 1日(day) (40歳(years old))		
Phone 000 - 123 - 4567		

Required fields: address, name, gender, date of birth and phone