

Examples

Entry spots (circle the most applicable items)

Medical Questionnaire

[Health checkup for late-stage elderly]

Please circle all that apply within the bold frames.

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, <u>headaches</u> , lightheadedness, tinnitus, diarrhea, constipation, bloating, feeling sick or other symptoms

No.	Questions	Answers (circle whichever applies)	
1 3	Currently, are you using any of the following medicine or injection?	a. medicine to lower blood pressure	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No
		b. medicine to lower blood sugar or insulin injections (diabetes medicine)	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
		c. medicine to lower cholesterol or triglycerides etc.	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No
4	How is your current health?	<input checked="" type="radio"/> ① Great <input type="radio"/> ② Good <input type="radio"/> ③ Normal	<input type="radio"/> ④ Not Good <input type="radio"/> ⑤ Bad
5	Are you satisfied with your daily life?	<input type="radio"/> ① Very much <input checked="" type="radio"/> ② Yes	<input type="radio"/> ③ Not so much <input type="radio"/> ④ No
6	Do you eat 3 meals a day?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
7	Has it become more difficult to chew hard foods within the last 6 months (like dried squid or pickled daikon, etc.)?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
8	Do you sometimes choke on tea, soup or other liquids?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No	
9	Have you lost more than 2 to 3 kgs within the last 6 months?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No	
10	Do you think you walk slower than before?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No	
11	Have you fallen within the last year?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
12	Do you walk or exercise at least 1 time every week?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
13	Have people around you told you that you are forgetful recently, or that you are always asking the same thing?	<input type="radio"/> ① Yes <input checked="" type="radio"/> ② No	
14	Do you sometimes forget what day or month it is?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
15	Do you smoke cigarettes?	<input type="radio"/> ① Yes <input type="radio"/> ② No <input checked="" type="radio"/> ③ I Quit	
16	Do you leave the house more than once a week?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
17	Do you regularly communicate or have contact with family or friends?	<input checked="" type="radio"/> ① Yes <input type="radio"/> ② No	
18	Do you have someone who you can talk to when you feel unwell?	<input checked="" type="radio"/> ① Yes <input 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.]
- It is necessary to enter your gender as medical examination criteria differ accordingly.

What to bring the day of your consultation

Insurance card, medical questionnaire (this form)

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.

Address	〒 604-8091 京都市中京区 寺町通御池下る下本能寺前町 500 番地 中信御池ビル 4 階		Insured person	Kyoto Prefecture Elderly Medical Care Association	
			Insured person number		
Katakana			Insurer number	3 9 2 6 1	
Name	京都 太郎	Sex	<input checked="" type="radio"/> Male <input type="radio"/> Female		
Date of Birth	1949 年(year) 5 月(month) 1 日(day) (75 歳(years old))				
Phone	000 - 123 - 4567				
			実施機関コード： 実施機関の所在地、名称、電話番号 医師氏名		

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