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: ________________________, ________________________
Family name, First name Middle name

□男 Male
□女 Female

生年月日
Date of Birth:

年齢
Age:

1．身体検査
Physical Examination

(1) 身　長
Height cm
体　重
Weight kg

(2) 血　圧
Blood pressure ____________mm/Hg～__________mm/Hg
血液型
Blood type

ABO	RH ＋ －

脈拍 □整 regular
Pulse □不整 irregular

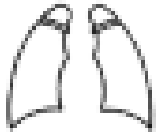
(3) 視　力
Eyesight: (R) (L) (R) (L)
裸眼 Without glasses　矯正 With glasses or contact lenses

色覚異常の有無 □正常 normal
Color blindness □異常 impaired

(4) 聴　力 □正常 normal
Hearing: □低下 impaired

言　語 □正常 normal
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 the applicant's chest x-rays (X-rays taken more than 6 months prior to this certification are NOT valid).



肺 □正常 normal
Lungs: □異常 impaired

← Date ________________
Film No.
____
Describe the condition of applicant's lungs.

心臓 □正常 normal
Cardiomegaly: □異常 impaired
↓
異常がある場合 ↘
心電図 Electrocardiograph :□正常 normal
□異常 impaired

3．現在治療中の病気 □Yes (Conditions/particulars:______________________________)
Under medical treatment at present □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 disease......□(. .)
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．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充分に留学に耐えうるものと思われますか？ Yes又はNoにチェックをしてください。
In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan?

Yes □　　No □

7．特記すべき事項
Particulars or additional comments:

日付
Date:__________________

署名
Signature:____

医　師　氏　名
Physician's Name (Print):____

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