Confidential

Medical checkup for the short-term exchange students

Date / /

※The certificate is valid for six months after getting it.

Examination No.	Name		Sex
	Birthday	/ / (Age)	1. Male 2. Female

Your medical history

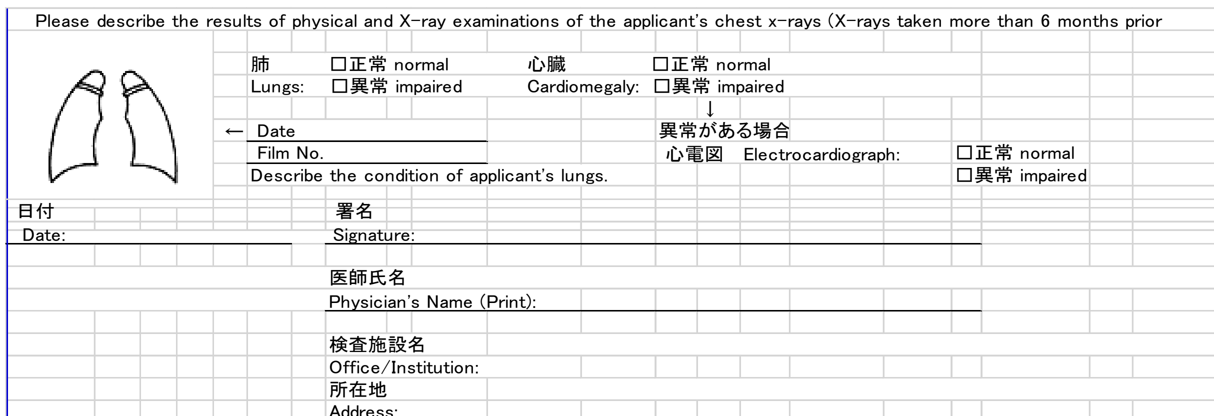
Name of Disease	Affected Area (Do you have?)	Present condition	Age of onset
1. Congenital heart disease	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
2. Arrhythmia	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
3. Cardiac noise	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
4. High-blood pressure	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
5. Thyroid disease	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
6. Stomach / Duodenum ulcer	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
7 ulcerous colitis	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
8. Nephritis	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
9. Nephrosis	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
10. Kidney / Urinary calculus	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
11. Liver disease	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
12. Diabetes	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
13. Spontaneous pneumothorax	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
14. Asthma	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
15. Lung tuberculosis	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
16. Epilepsy	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
17. Mental disease	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
18. Hyperventilation syndrome	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
19. Food allergy	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
20. Drug allergy	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
21. Hearing disorder	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
22. Vision disorder	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
23. Limbs disorder	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
24. Developmental disability	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
25. Measles	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
26. Rubella	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
27. Mumps	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
28. Chickenpox	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
29. Others	No / Yes	1.Cured 2.Under Treatment 3.Untreated	
→ If Yes, fill in the disease name you have/had ( )			

Immunization Record

Have you got the vacicinations named below?		
MMR (Measles, Mumps, Rubella)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
MR (Measles, Rubella) (1st dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
MR (Measles, Rubella) (2nd dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
Measles (1st dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
Measles (2nd dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
Rubella (1st dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
Rubella (2nd dose)	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No
Mumps	Yes If yes, list the date ↓ / / Date/ Month /Year	No
Chicken-pox	Yes If yes, fill in the date ↓ / / Date/ Month /Year	No

Blood type:
O / A / B / AB (+) (-)
Are you currently taking any medications?
If Yes, fill in the medication name ↓ Yes / No ( )
Do you have a physical disability certificate?
If Yes, fill in the cirtificate name ↓ Yes / No ( )

※Please seek doctor's instruction if you declare any medical history stated above. In case you are diagnosed as possibly having an infectious desease, please take the X-ray examination if needed and fill in the result as below,by following the doctor doctor's advise



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

肺 Lungs: ☐正常 normal ☐異常 impaired

心臓 Cardiomegaly: ☐正常 normal ☐異常 impaired

↓ 異常がある場合

心電図 Electrocardiograph: ☐正常 normal ☐異常 impaired

← Date

Film No.

Describe the condition of applicant's lungs.

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: