HEALTH QUESTIONNAIRE

Please confirm your personal information.
If you find any errors, please correct.

一般財団法人 日本健診財団

0007097778BAAA

英語

Establishment name (99999000) サンプル事業所	Gender 男	Birthday 1980/05/02	44	present date 令和7年3月31日		
	Name of insurance member			Relationship 本人		
(0007097778) サンプル タロウ	Insurance symbol 3451	Insurance number 222		加入		
Name サンプル 太郎	Department					
	Employee number 0123456789					

Home address 〒

受診日

受付番号

Home or mobile number

【You fill it out beforehand, and take it】 ※mark entry example ⇒ Please mark with a HB grade pencil or an automatic pencil so as not to protrude.

About personal information collection of ☐ Agree

Last meal in the past ☐ yester day ☐ today ☐☐:☐☐

Pregnant, including the possibility of pregnancy ☐ Yes ☐ No

in the menstruation ☐ Yes ☐ No

◆ Occupation; Please mark one item below.

☐ 1 Technologist ☐ 2 Manager ☐ 3 Office worker ☐ 4 Sales position ☐ 5 Sales worker ☐ 6 Farmer/Fisher ☐ 7 Miner ☐ 8 Industry worker ☐ 9 Civil engineering ☐ 10 Transportation/Communication ☐ 11 Security position ☐ 12 Service industry ☐ 13 Other

◆ Please mark each item about your work history.

1 Have you ever handled heavy objects in your work? ☐ Yes ☐ No

2 Have you ever worked in an environment with lots of rocks, sand, or dust? ☐ Yes ☐ No

3 Have you ever used a machine that vibrates at high speed in your work? ☐ Yes ☐ No

4 Have you ever handled a hazardous substance in your work? ☐ Yes ☐ No

5 Have you ever handled radiation in your work? ☐ Yes ☐ No

6 What is your current work shift?

☐ Always on a day shift ☐ Always on a night shift ☐ On an alternative shift (Both day and night shifts)

7 What are your average hours worked per day at your current workplace during the past month (excluding lunchtime and break time and including overtime)?

☐ Less than 6 hours ☐ 6 or more hours and less than 8 hours
☐ 8 or more hours and less than 10 hours ☐ 10 or more hours

8 What are your average days worked per week at your current workplace during the past month?

☐ Less than 3 days ☐ 3 or more days and less than 5 days
☐ 5 days ☐ 6 or more days

◆ Please mark an applicable thing about subjective symptoms within one year. ☐ None

☐ 1 Have a headache ☐ 2 Dysphagia ☐ 3 Sudden weight loss (more than 3-4 kg / month) ☐ 4 Pain in a chest, The chest a tightened ☐ 5 Discomfort (or Pain) of the pit of the stomach ☐ 6 Sleepless, Depression, Strong feeling of anxiety ☐ 7 Cough, Sputum ☐ 8 Diarrhea, Constipation ☐ 9 Thirsty, Over volume of urinary output ☐ 10 Bloody sputum ☐ 11 Hematoc hezia ☐ 12 A pulse is fast (or irregular) ☐ 13 Other symptom which influence on daily life [ ]

◆ When you continue to be under management for each disease, please check a box in a line "present". When you had any diseases in the past, please check a box in a line "past" ☐ None

Past	Present		Please answer the questions if you marked "during treatment"
☐ 1 Hypertension	☐ ⇒	Do you have any medicine for hypertension?	☐ Yes ☐ No
☐ 2 Diabetes mellitus	☐ ⇒	Do you have any medicine for diabetes, including insulin injection?	☐ Yes ☐ No
☐ 3 Dyslipidemia	☐ ⇒	Do you have any medicine for hyperlipidemia, especially high level of serum LDL-cholesterol?	☐ Yes ☐ No

Past	Present	Past	Present	Past	Present
☐ 4 Hyperuricemia (gout)	☐	☐ 31 Hearing impairment (Difficulty in hearing)	☐	☐ 54 Gastric ulcer	☐
☐ 11 Stroke	☐	☐ 41 Lung cancer	☐	☐ 55 Stomach polyp	☐
☐ 12 Myocardial infarction	☐	☐ 42 Pulmonary tuberculosis	☐	☐ 56 Duodenal ulcer	☐
☐ 13 Angina	☐	☐ 43 Pneumonia	☐	☐ 57 Colon cancer	☐
☐ 14 Arrhythmia	☐	☐ 44 Asthma	☐	☐ 58 Colon polyp	☐
☐ 15 Heart valve disease	☐	☐ 45 Sleep apnea syndrome	☐	☐ 59 Ulcerative colitis	☐
☐ 16 Cardiomyopathy	☐	☐ 51 Reflux oesophagitis	☐	☐ 60 Crohn's disease	☐
☐ 17 Aortic aneurysm	☐	☐ 52 Esophageal cancer	☐	☐ 71 Liver cancer	☐
☐ 19 Other heart disease	☐	☐ 53 Stomach cancer	☐	☐ 72 Cirrhosis	☐
☐ 21 Glaucoma	☐				

Past	Present	Past	Present
☐ 73 Fatty liver	☐	☐ 122 Malignant lymphoma	☐
☐ 74 Chronic hepatitis B	☐	☐ 123 Leukemia	☐
☐ 75 Chronic hepatitis C	☐	☐ 131 Prostate cancer	☐
☐ 81 Gall stone	☐	☐ 132 Prostate hypertrophy	☐
☐ 82 Gallbladder polyp	☐	☐ 141 Breast cancer	☐
☐ 91 Pancreas cancer	☐	☐ 151 Uterine myoma	☐
☐ 101 Renal cancer	☐	☐ 152 Cervical cancer	☐
☐ 102 Nephritis	☐	☐ 153 Uterine cancer	☐
☐ 103 Urinary stone	☐	☐ 154 Ovarian cyst	☐
☐ 104 Chronic renal failure	☐		
☐ 111 Thyroid disease	☐	☐ 999 Other large disease which is needed hospitalization or surgery	☐
☐ 112 Articular rheumatism	☐	[ ]	
☐ 121 Anemia	☐		

◆ Please mark each item below.

1 Have you ever been told by the doctor you have had a stroke (cerebral hemorrhage, brain infarction, etc.) and received treatment? ☐ Yes ☐ No

2 Have you ever been told by the doctor you have a heart disease (angina pectoris, myocardial infarction, etc.) and received treatment? ☐ Yes ☐ No

3 Have you ever been diagnosed as having chronic kidney disease or kidney failure and received treatment (dialysis therapy)? ☐ Yes ☐ No

4 Have you ever been diagnosed as anemic? ☐ Yes ☐ No

5 Do you smoke habitually? ※1

☐ Yes (※1 meets both condition 1 and 2)
☐ Used to smoke, but haven't smoked in the past month. (※1 meets only condition 2)
☐ No

※1 "habitually" referes to meets both condition 1 and 2 below.
condition 1 : smoking continuing during the recent one month
condition 2 : have smoked for more than 6 months or more than 100 pieces one started smoking

6 Have you gained more than 10kg compared to when you were at the age of 20? ☐ Yes ☐ No

7 Do you exercise which the body sweats lightly for more than 30 minutes per day twice a week, more than a year? ☐ Yes ☐ No

8 Do you perform walking exercise or physical activity equivalent to it more than one hour a day? ☐ Yes ☐ No

9 Do you walk faster than people with the same sex in your generation? ☐ Yes ☐ No

10 What is the following condition when eating?

☐ I can bite anything ☐ I can hardly bite
☐ Sometimes I can hardly bite, as I am concened about teeth, gums, and bite

11 Do you eat faster than people around you?

☐ Faster ☐ Normal ☐ Slower

12 Do you have an evening meal within 2 hours before going to bed more than three times a week? ☐ Yes ☐ No

13 Do you take snacks and drinks other than three meals?

☐ Every day ☐ Occasionally ☐ I hardly take a snack

14 Do you skip breakfast more than three times a week? ☐ Yes ☐ No

15 How much is the frequency to drink alcohol (refined sake, distilled spirit, beer, whisky and wine et al)?

☐ Every day ☐ Occasionally (5-6 days a week) ☐ Occasionally (3-4 days a week)
☐ Occasionally (1-2 days a week) ☐ Occasionally (1-3 days a month) ☐ Occasionally (Less than 1 day a month)
☐ Quit drinking ※2 ☐ Rarely drink (Cannot drink)

※2 "Quit drinking" had a habit of drinking alcohol once a month or more in the past, but have not consumed alcoholic beverages in the past year or more

16 How much do you drink alcohol per day? ※3

☐ Less than 1 unit ☐ 1 to less than 2 units ☐ 2 to less than 3 units
☐ 3 to less than 5 units ☐ More than 5 units

※3 1 unit = 180ml of sake(15 degrees), 500ml of beer(5 degrees), 110ml of shochu(25 degrees), 180ml of wine(14 degrees), 60ml of whiskey(43 degrees), 500ml of canned chuhai(5 degrees), 350ml of canned chuhai(7 degrees)

17 Do you get enough sleep to recover from activities? ☐ Yes ☐ No

18 Would you like to make life style changes including food habits and physical exercises?

☐ No ☐ I am going to change it roughly within 6 months.
☐ I am going to change it in the future, or I have started little by little.
☐ I started only within 6 months ago. ☐ I already started more than 6 months ago.

19 Have you ever received Specific Health Guidance for improving your lifestyle habits? ☐ Yes ☐ No

20 Do you have any health issue on which you need consultation? ☐ Yes ☐ No

◆ Please mark the ones that apply to H. pylori testing.

① Have you ever been tested for H. pylori?	☐ Yes (Go to question ②)	☐ No	
② How was the result of the H. pylori test?	☐ Positive (Go to question ③)	☐ Negative	☐ Unknown
③ Were you treated for eradication?	☐ Treated (Go to question ④)	☐ Not treated	☐ Unknown
④ Which was the result of the eradication therapy?	☐ Successful	☐ Failure	☐ Unconfirmed

◆ Please answer below questions when you have barium swallowing test for your digestive organ such as stomach. Do you have any symptom or diseases in the past? ☐ I do not meet any items.

☐ 1 Have you ever had allergy when you took barium?
☐ 2 Do you have constipation? Or is today the third day when you had last defecation?
☐ 3 I am undergoing artificial dialysis, I constructed an artificial anus.
☐ 4 Have you ever had ileus in the past?
☐ 5 Have you ever had gastric or duodenal ulcer, or operation in your abdomen?
☐ 6 Do you have any management for ulcerative colitis or Crohn' s disease?