Physical Examination Form <Workplace medical exam>

Exam date
Exam No.

<Personal Information Policy>
Personal Information received for physical examination will be used to analyze and report the results of laboratory tests. It will be also used to recommend you for physician visits or follow up check in case extensive testing or re-examination is required. Please refer to our home page (http://www.npmhc.jp) for the details of our personal information policy. If our handling and utilization of personal information outlined above meet with your approval, please put a ring around the "I agree".
"I agree"

Please fill out this form before giving to the receptionist

●Use HB pencil or 0.5mm mechanical pencil only.
(Do not use ball point or fountain pens)

◆Which job category describes your current occupation?
1. Clerical 2. Technical/research 3. Production/skilled 4. Civil engineering/construction 5. Transportation 6. Sales/marketing 7. Guard/security service 8. Teaching 9. Customer service 11. Police 12. Self Defence Force personnel 13. Medical care personnel 10. Other ( )

Your occupation during your previous physical exam was,

●Enter number if no occupation is shown at left or is different from current occupation.
Align to the right

◆Mark only one answer for each question with a diagonal slash in the box ☒

1	Are you currently taking medication for blood pressure?	☐ Yes	☐ No
2	Are you currently taking blood sugar medication or using insulin?	☐ Yes	☐ No
3	Are you currently taking medication to lower cholestrol or neutral fat?	☐ Yes	☐ No
4	Have you ever been diagnosed with or treated for stroke or cerebral hemorrhage?	☐ Yes	☐ No
5	Have you ever been diagnosed with or treated for cardiac disease (angina, heart attack)?	☐ Yes	☐ No
6	Have you ever been diagnosed with chronic liver disorder or are currently on dialysis?	☐ Yes	☐ No
7	Have you ever been diagnosed with anemia?	☐ Yes	☐ No
8	Are you a habitual smoker? (including electronic cigarettes) ⇒Over 100 cigaretttes in past month or have been smoking for more than 6 months	☐ Yes	☐ No
9	Have you gained more than 10kg from when you were 20 years old?	☐ Yes	☐ No
10	Have you been exercising 30 minutes or more, twice a week for at least 1 year?	☐ Yes	☐ No
11	Do you walk or do any equivalent amount of physical activity more than one hour a day in your daily life?	☐ Yes	☐ No
12	Do you walk faster than other people of your same age and sex?	☐ Yes	☐ No
13	Which best describes your chewing during a meal?	☐ Can chew anything	☐ Difficulty sometimes ☐ Can hardly chew at all
14	Do you eat faster than other people?	☐ Faster	☐ Normal ☐ Slower
15	Do you eat dinner within 2 hours before sleeping more than 3 times a week?	☐ Yes	☐ No
16	Do you snack or consume sweet beverages between regular meals?	☐ Every day	☐ Sometimes ☐ Almost none
17	Do you skip breakfast more than 3 times a week?	☐ Yes	☐ No

18	How often do you drink?	☐ Every day ☐ Sometimes ☐ Almost none
19	For alcohol drinkers ⇒ How much alcohol do you consume daily? ***180ml sake** is equivalent of. Beer 500ml Shochu (25% alcohol) 110ml Whiskey double shot 60ml Wine 2 glasses 240ml	☐ Less than 180ml(sake) ☐ 180ml～360ml(sake) ☐ 360ml～540ml(sake) ☐ More than 540ml(sake)
20	Do you feel fully rested after sleeping?	☐ Yes ☐ No
21	Would you like to improve your lifestyle habits such as diet and physical activity?	☐ No plans ☐ Slowly started just recently ☐ Already started (more than 6 months ago) ☐ Intend to begin within the next 6 months ☐ Already started (less than 6 months)
22	Would you like to receive lifestyle modification health guidance if offered?	☐ Yes ☐ No

Medical treatment status
Mark all medical conditions you are currently undergoing treatment for.

☐ None

☐ Heart disease (Angina, coronary) ☐ Anemia ☐ Prostatic disease
☐ Hepatobiliary disease ☐ Thyroid disease ☐ Eye disease
☐ High uric acid (including gout) ☐ Respiratory disease ☐ Ear disease

Subjective symptoms
Mark with a ☑ if you have any of the following symptoms.

☐ None

☐ Headaches ☐ Wamble ☐ Breath shortness ☐ Chest pains
☐ Dizziness ☐ Palpitations ☐ Chest tightness ☐ Swelling of face/limbs

Women only Mark with a ☑ if applicable.

☐ Pregnant (potentially) ☐ Menstruation

Organization			
Department/Section			
Name		Gender	1.Male 2.Female
Birthdate	(yyyy/mm/dd)	Age	
Insurer name Insurer number		Insurance card symbol ・number	

＊Please do not fill here.