

Guide for "Physical Examination Form" for persons who handle organic solvents

Pls. use HB pencil or 0.5mm mechanical/propelling pencil to fill in the form.

<Personal Information Policy>

◆ If our handling and use of your personal information outlined is acceptable to you, please circle the phrase "I Agree".

◆ If not printed, please be sure to fill in <Organization>, <Dept/Sect> <Name>, <Gender>, <Age>, <Birthdate>. If the printed information needs to be changed please change it.

<Classification>

◆ Please choose one and write the number in the box.
 ◇◇ If you have worked with organic solvents in the past, please fill in the total number of years that you have worked with them.
 Also, please fill in the total number of years that you have worked with organic solvents at your current organization.

<Job description>

◆ Please choose one and write the number in the box.

<Medical History>

◆ If you have been hospitalized and/or received outpatient treatment due to organic solvents please choose "YES" and fill in the disease name.
 ◇◇ Otherwise select "NO".

<Subjective Symptoms>

◆ Please select "all" symptoms that apply to you. Mark the box/es with a diagonal line like this

◇◇ If you have no subjective symptoms, please choose "None".

Physical Examination Form

Date

No.

(for persons who handle organic solvents)

<Personal Information Policy>

Personal Information received for your physical examination will be used to analyze and report the results of laboratory tests. It will also be used to recommend you for physician visits should more detailed tests or re-examination be required. Please refer to our home page (<http://www.npmhc.jp>) for the details of our personal information policy. If our handling and use of your personal information outlined is acceptable to you, please circle the phrase "I Agree".

"I Agree"

*Please fill in the blanks if they are not already printed.

Organization	Organization
Department/Section	Department/
Name	Section Code
Birthdate (yyyy/mm/dd)	Personal Code
Gender	Consultation No.

* Please do not write here.

★ Please answer to the medical questioning whether you experience the symptoms. If the printed information needs to be changed please change it

012345

Classification

1. Newly Employed 2. Transferred 3. Periodic checkup

The total number of years you have worked with organic solvents in the past. For years months

The total number of years that you have worked with organic solvents in your current organization From ~

Please choose your occupation (only one)

- | | |
|---------------------------|---------------|
| 01. Solvent manufacturing | 07. Bonding |
| 02. Manufacturing | 08. Washing |
| 03. Printing | 09. Painting |
| 04. Drawing/lithography | 10. Drying |
| 05. Fabrication | 11. Research |
| 06. Adhesive coatings | 12. Tank work |

Medical History

* Have you ever been hospitalized and/or received outpatient treatment due to organic solvents?

1. NO 2. YES => disease name ()

Subjective Symptoms

Please select all symptoms that you experience at all times or while at work.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> 5. Vomit | <input type="checkbox"/> 10. Difficulty sleeping | <input type="checkbox"/> 15. Soreness in eyes and nose and throat |
| <input type="checkbox"/> 1. Feel heavy-headed | <input type="checkbox"/> 6. No appetite | <input type="checkbox"/> 11. Feel anxiety | <input type="checkbox"/> 17. Pain in hands or feet |
| <input type="checkbox"/> 2. Headache | <input type="checkbox"/> 7. Stomachache | <input type="checkbox"/> 12. Feel frustrated | <input type="checkbox"/> 18. Numbness in hands or feet |
| <input type="checkbox"/> 3. Feel dizzy | <input type="checkbox"/> 8. Lost weight | <input type="checkbox"/> 13. Poor concentration | <input type="checkbox"/> 19. Weak grip |
| <input type="checkbox"/> 4. Feel nausea | <input type="checkbox"/> 9. Feel palpitations | <input type="checkbox"/> 14. Hands and fingers tremble | <input type="checkbox"/> 21. Reduced vision |
| <input type="checkbox"/> 22. Any other symptoms () | | | |

* Please do not write here.