

**CERTIFICATE OF HEALTH 健康診断書**  
【This form has to be filled out by a physician.】

Please fill out this form in English (in Roman block capitals).

NAME OF APPLICANT 申請者氏名	SEX 性別 M. 男 F. 女	AGE 歳	DATE OF BIRTH 生年月日
PRESENT ADDRESS 現住所			BLOOD TYPE 血液型 (Rh: +, - )
DIETARY RESTRICTIONS DUE TO RELIGIOUS OR PHYSICAL REASONS 宗教的又は身体的理由で制限すべき食べもの			

1. Height 身長 \_\_\_\_\_ cm. Sit-Height 座高 \_\_\_\_\_ cm. Weight 体重 \_\_\_\_\_ kg.  
Blood Pressure 血圧: Sys. \_\_\_\_/Dia. \_\_\_\_ mmHg Pulse Rate 脈拍数: \_\_\_\_ /m ☐ Reg. 整脈 ☐ Irreg. 不整脈  
Reflexes 反射: Pupil 瞳孔: ☐ Normal, ☐ Abnormal Knee 膝: ☐ Normal, ☐ Abnormal  
Others 他( ): ☐ Normal, ☐ Abnormal

Eyesight 視力:	Left 左	Right 右	Color-Blindness 色盲:	Hearing 聴力:
without glasses _____			Yes: ( )	Left 左: _____
(with glasses 矯正) ( ) ( )			No	Right 右: _____

**2. Anamnesis 既往症: Please indicate with + or -**

.... Tuberculosis 結核 .... Malaria マラリア .... Other Communicable Diseases その他の伝染病  
.... Rheumatism リウマチ .... Epilepsy てんかん .... Kidney Disease 腎臓病 .... Liver Disease 肝臓病  
.... Asthma ぜんそく .... Cardiac Disease 心臓病 .... Diabetes 糖尿病 .... Allergy アレルギー

**3. Present Conditions 現在の体調: Please indicate with +, if you find any disease or abnormality, or with -, if not.**

.... Tonsils, Nose or Throat のど・鼻の異常 .... Heart or Blood Vessels 心臓・血管の異常  
.... Lungs or Respiratory System 肺・呼吸器系の異常 .... Stomach or Digestive System 胃・消化器系の異常  
.... Genito-Urinary System 泌尿器系の異常 .... Other Abdominal Organs その他内臓の異常  
.... Brain or Nervous System 脳・神経系の異常 .... Blood or Endocrine System 血液・分泌系の異常  
.... Bones, Joints or Locomotor System 骨・関節・運動系の異常  
.... Skin 皮膚 .... Venereal Disease 性病 .... Pregnancy 妊娠  
.... nervous or mental disorder 精神の障害

**4. If you marked + to any of the above 2 and 3, please describe in detail each disease, and if the applicant is physically handicapped, the abnormality or impairment.** 上記2 または3 で「+」がある場合は、  
各々の症状について詳しく記入してください。また、申請者が身体に障害を持っている場合、その部位、程度について記入してください。

**5. Describe in full on conditions of applicant's lungs: (including the result of Chest X-ray examination and its date)** 申請者の胸部疾患の有無について記入してください。X線撮影の結果と日付についても記入してください。

DATE (Day/Month/Year) of the examination \_\_\_\_\_

**6. In your opinion, the applicant's health, physical and mental conditions are: (Please check)**

Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**7. In your opinion, the applicant is physically and mentally fit to go abroad for study and travel: (Please check)**

Yes \_\_\_\_\_ No \_\_\_\_\_

NAME & TITLE OF PHYSICIAN (\*Please print) \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_

DATE (Day/Month/Year) \_\_\_\_\_