健康診断書（医学部、附属病院以外の部署訪問者）
CERTIFICATE OF HEALTH (to be completed by the examining physician)

Applicant to School of Medicine and University Hospital use another format.

日本語または英語により明瞭に記載すること Please fill out (PRINT/TYPE) in Japanese or English.

氏名
Name:____________________, ______________________________ Gender_______ 生年月日 Date of birth _____/______/_____ age ____
Family name First name Middle name (D/M/Y)

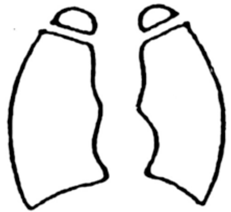
1 身体検査 Physical Examinations

身長 Height _______cm 体重 Weight ______Kg 血圧 BP ______/______mmHg 脈拍 Pulse ____/min ☐整 regular ☐不整 irregular 血液型 Blood Type A B O RH ＋ －

視力 Eyesight Rt.______/Lt.______ 裸眼（without glasses） Rt.______/Lt.______ 矯正（with glasses） 聴覚 hearing ☐ 正常 normal ☐ 異常 impaired 言語 language ☐ 正常 normal ☐ 異常 impaired

2 胸部聴診およびX線写真（6か月以内） Chest physical and X-ray examination **(within 6 months*)**

*If applicant have already checked chest Xp for VISA at institution authorized by Japanese government, attach copy of certification instead additional test.



Date_____ /____ /_____(D/M/Y)

Film No.______________

肺 Lung ☐正常 normal ☐異常 impaired →Describe the condition

____

____

心臓 Heart ☐正常 normal ☐異常 impaired →Describe the condition and check ECG

ECG ☐正常 normal ☐異常 impaired

3 現在治療中の病気 Diseases currently being treated ☐無 None ☐有 Yes

If yes, please describe detail:

____

4 既往症 Past History ☐なし None ☐ありYes. If yes, please check and describe detail.

☐ Tuberculosis ☐ Malaria ☐ Other communicable disease ☐ Kidney disease ☐ Epilepsy
☐ Heart disease ☐ Diabetes ☐ Drug Allergy ☐ Psychiatric disease
☐ Functional disorder in extremities ☐ Others（Disease______________________________）

Detail:

____

5 検査 Laboratory tests

検尿 Urinalysis: glucose ( ), protein ( ), occult blood ( )

血沈 ESR ______ mm/hr 白血球 WBC________ /μL 血色素数Hemoglobin ________ g/dl

肝機能 ALT________IU/L AST________IU/L γ-GT________IU/L

6 3種混合予防接種 MMR immunization **(Strongly recommend to get MMR immunization before coming to Japan)**

MMR immunization First dose: ______/_____/______ (D/M/Y), Second dose: ______/_____/______ (D/M/Y)

	Date of disease (if applicable)	Date of Serologic positive (if applicable)
Measles	______/_____/______ (D/M/Y)	______/_____/______ (D/M/Y)
Mumps	______/_____/______ (D/M/Y)	______/_____/______ (D/M/Y)
Rubella	______/_____/______ (D/M/Y)	______/_____/______ (D/M/Y)

7 診断医の意見 Physician's impression of the applicant's health （継続的治療・投薬の必要性があれば、御記入ください Please fill in if the applicant needs regular medication or treatment.）

____

8 志願者の既往歴、診察・検査の結果から判断して、現在の健康の状況は充分に日本への留学に耐えうるものと思われますか?
In view of the applicant's history and the above findings, is it your observation applicant's health status is adequate to pursue study/research in Japan? ☐ Yes, ☐ No

日付
Date ______/______/______
(D/M/Y)

署名
Signature:________________________________

医師氏名
Physician's name:________________________________

検査施設名
Office/ Institution:________________________________

所在地
Address:________________________________

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