健康診断書（医学部・医学部附属病院）
CERTIFICATE OF HEALTH for applicants to School of Medicine and University Hospital
(to be completed by the examining physician)

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_____
Family name First name Middle name

生年月日
Date of birth _____/_____/_____ age ____
(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 A B O RH＋－ Blood Type

視力 Eyesight 裸眼（without glasses） Rt._____/Lt._____ 矯正（with glasses） Rt._____/Lt._____

聴覚 ☐ 正常 normal ☐ 異常 impaired

言語 ☐ 正常 normal ☐ 異常 impaired

2 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:

_____

_____

3 現在治療中の病気 Diseases currently being treated ☐無 None ☐有 Yes
If yes, please describe detail:

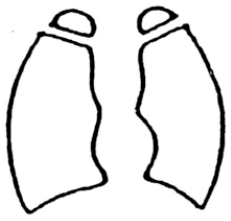
_____

_____

_____

4 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

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

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6 予防接種 immunization history
(Applicants must receive the vaccinations of Measles, Mumps, Rubella, Varicella, and Hepatitis B, OR reveal positive serological results)

a. Measles, Mumps, Rubella (MMR)

First dose: _____/_____/_____ (D/M/Y), Second dose: _____/_____/_____ (D/M/Y)
Date of Serologic positive (if applicable)
Measles _____/_____/_____ Mumps _____/_____/_____ (D/M/Y) Rubella _____/_____/_____ (D/M/Y)

b. Varicella

First dose: _____/_____/_____ (D/M/Y), Second dose: _____/_____/_____ (D/M/Y)
Date of Serologic positive (if applicable) _____/_____/_____ (D/M/Y)

c. Hepatitis B (HBs antibody at least 1 month after completion of 3 consecutive doses of vaccination)

Date: _____/_____/_____ (D/M/Y), Titer and Result : _____ (Negative・Positive)

d. Tuberculosis

Baseline 1-step TB skin test (TST) or Interferon-gamma release assay (IGRA) **within the last 3 months**

Date: _____/_____/_____ (D/M/Y),

Induration and Result : TST _____x_____mm (Negative・Positive)

or IGRA (QFT, T-SPOT) (Negative・Positive)

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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