

# 健康診断書 (2021年度版)

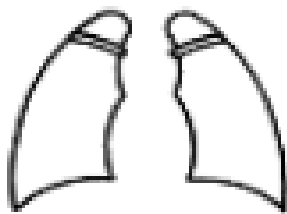
(医師に記入してもらうこと)  
日本語又は英語により明瞭に記載すること。

# CERTIFICATE OF HEALTH (for 2021)

(to be completed by the examining physician)  
Please fill out (PRINT/TYPE) in Japanese or English.

|              |                    |                       |                       |
|--------------|--------------------|-----------------------|-----------------------|
| 氏名<br>Name   | 姓<br>Surname       | 名<br>Given name       | ミドルネーム<br>Middle name |
| 性別<br>Gender | 男 Male<br>女 Female | 生年月日<br>Date of Birth | 年 月 日<br>yyyy mm dd   |

|  |   |                               |                          |
|--|---|-------------------------------|--------------------------|
| <b>1. 身体検査</b><br>Physical examination |   |                               |                          |
| (1)身長<br>Height                        | cm  | (2)体重<br>Weight               | kg                       |
| (3)血圧<br>Blood pressure                | mmHg ~ mmHg   | (4)血液型<br>Blood type          | A B AB O RH + RH -       |
| (5)脈拍<br>Pulse                         | 整 Regular<br>不整 Irregular   | (7)色覚異常の有無<br>Color blindness | 正常 Normal<br>異常 Impaired |
| (6)視力 Eyesight                         | 裸眼 (右) (左)<br>Without glasses (R) (L)<br>矯正 (右) (左)<br>With glasses or contact lenses (R) (L) | (8)聴力<br>Hearing              | 正常 Normal<br>異常 Impaired |
|  |   | (9)言語<br>Speech               | 正常 Normal<br>異常 Impaired |

|  |   |                          |                          |
|--|---|--------------------------|--------------------------|
| <b>2. 胸部聴診及びX線検査 (6ヶ月以内)</b><br>Physical and X-ray examinations of the chest (within six months) |   |                          |                          |
|                 | 胸部X線所見<br>Describe the condition of lungs.    | 撮影年月日<br>Date of X-ray   | 年 月 日<br>yyyy mm dd      |
|  |   | フィルム番号<br>Film No.       |                          |
|  |   | (1)肺<br>Lungs            | 正常 Normal<br>異常 Impaired |
|  |   | (2)心臓<br>Cardiomegaly    | 正常 Normal<br>異常 Impaired |
|  | 異常がある場合 心電図<br>If impaired Electrocardiograph | 正常 Normal<br>異常 Impaired |                          |

|   |                         |
|---|-------------------------|
| <b>3. 現在治療中の病気</b><br>Disease currently being treated | 無 No 有 Yes : 病名 Disease |
|---|-------------------------|

|  |            |                                      |   |   |  |   |
|--|------------|--------------------------------------|---|---|--|---|
| <b>4. 既往症</b><br>Past illness/disorder   | ✓          | 病名Name                               | 完治時期/治療中<br>Date of recovery /under treatment | ✓ | 病名Name   | 完治時期/治療中<br>Date of recovery /under treatment |
| 該当するものにチェックと完治時期/治療中を記入、いずれも該当しない場合は「無し」にチェックすること。<br>Please check and fill in the date of recovery/under treatment. If NOT contracted any of them in the past, please check "None". |            | 結核<br>Tuberculosis                   |   |   | マラリア<br>Malaria                                  |   |
|  |            | その他感染症<br>Other communicable disease |   |   | てんかん<br>Epilepsy                                 |   |
|  |            | 腎疾患<br>Kidney disease                |   |   | 心疾患<br>Heart disease                             |   |
|  |            | 糖尿病<br>Diabetes                      |   |   | 薬剤アレルギー<br>Drug allergy                          |   |
| ✓  | 無し<br>None | 精神疾患<br>Psychosis                    |   |   | 四肢機能障害<br>Functional disorder in the extremities |   |

|                                  |              |                   |                    |              |  |  |  |
|----------------------------------|--------------|-------------------|--------------------|--------------|--|--|--|
| <b>5. 検査</b><br>Laboratory tests |              |                   |                    |              |  |  |  |
| (1)尿検査<br>Urinalysis             | 糖<br>glucose | 蛋白<br>protein     | 潜血<br>occult blood |              |  |  |  |
| (2)貧血検査<br>Anemia test           | 赤沈<br>ESR    | 白血球数<br>WBC count | 血色素量<br>Hemoglobin | 貧血<br>Anemia |  |  |  |
| (3)肝機能検査<br>LFT                  | GPT<br>(ALT) | GOT<br>(AST)      | γ-GTP              |              |  |  |  |
|                                  | (IU/l)       | (IU/l)            | (IU/l)             |              |  |  |  |

|  |
|--|
| <b>6. 医師の診断・意見</b><br>Physician's impression of the applicant's health<br>継続的治療・投薬の必要性があればその旨ご記入下さい。<br>Please fill in if the applicant needs regular medication or treatment. |
|--|

|  |                               |
|--|-------------------------------|
| <b>7. In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue studies in Japan? 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十分に留学に耐えうるものと思われますか?</b><br><br><b>YES (はい) NO (いいえ)</b><br><br>Please be sure to check either "YES" or "NO". If you do not check "YES", the Embassy will NOT accept the application.<br>必ず「はい」又は「いいえ」にチェックしてください。「はい」にチェックがない場合、大使館は申請を受理しません。 | 日付<br>Date                    |
|  | 医師署名<br>Physician's Signature |
|  | 検査施設名<br>Office/Institution   |
|  | 所在地<br>Address                |