

Health check's application form

Furigana(Pronunciation)			<input type="checkbox"/> Male
Name			<input type="checkbox"/> Female
Date of birth	DD	MM	YYYY (Age)
Do you have any illnesses that you are currently treating? and What is the name of the medication you are taking? <input type="checkbox"/> None <input type="checkbox"/> have/had	Major illness/surgery in the past, or illness currently		
	From what age (ex.) 42~	illness name high blood pressure	medication / treatment Amlodipine
Tabacco	1. I don't smoke. 2. Smoke about ___ cigarettes /day · ___ years smoke 3. I used to smoke for ___ years. About ___ cigarettes /day		
Alcohol	1. Do not drink at all. 2. Drink ___ times a week. About ___ glass(es)/can(s)/bottle(s)		
When was the last time you ate something?	[Today	[am	_____ o'clock
At the time of Vision Test	1. naked eyes 2. contact lens 3. using glasses		
Only Female	Are you on your period now? (No · Yes · almost over)		
Address	〒		
Phone number	(mobile)	(home)	
Receipt addressee			
How to receive	1. Visit 2. Mail(need 110yen for stamp·write an envelope) 3. e-mail		
E-mail(optional/In case of trouble)			

Have you ever worked or been engaged in the following job categories.

Acclimate of high temperature / high humidity or extremely low temperature.	No	Yes	If you have ever fallen ill or developed an illness due to the work. Please write in detail.
Been exposed to radioactive material(s) in the atmosphere.	No	Yes	
Have experienced extreme enclosed pressure(such as deep sea diving).	No	Yes	
Have experienced use of high impact machinery(such as rock crushing machines or chain saw).	No	Yes	
Have handled any potentially harmful or hazardous materials.	No	Yes	
Been exposed to toxic or hazardous chemicals	No	Yes	
Been exposed to noxious gas(es) or been exposed to the area where this may have existed	No	Yes	
Been exposed to any viral pathogens	No	Yes	

staff use only