How to complete the Medical Questionnaire

1. Please use a pencil or mechanical pencil
2. Complete the form and wait for further instructions
3. Do not fold, soil, or damage this form as it will be processed by a machine

Example ☒

1. Current and Past Medical History (Do you have any current illnesses or a history of previous illnesses?)

None ☐

If you have marked "None," please proceed to the

	Under treatment (on medication)	Under treatment (not on medication)	Fully recovered
High blood pressure	☐	☐	☐
Myocardial infarction / Angina	☐	☐	☐
Arrhythmia	☐	☐	☐
Stroke (Cerebral infarction / Hemorrhage)	☐	☐	☐
Diabetes	☐	☐	☐
Dyslipidemia	☐	☐	☐
Gout	☐	☐	☐
Kidney illness	☐	☐	☐
Kidney failure	☐	☐	☐
Kidney stones	☐	☐	☐
Anemia	☐	☐	☐
Hepatitis	☐	☐	☐
Liver cirrhosis	☐	☐	☐
Fatty liver	☐	☐	☐
Gallbladder disease	☐	☐	☐
Pulmonary tuberculosis	☐	☐	☐
Gastric or Duodenal ulcer	☐	☐	☐
Gastritis	☐	☐	☐

	Under treatment (on medication)	Under treatment (not on medication)	Fully recovered
Enlarged prostate	☐	☐	☐
Cataract	☐	☐	☐
Glaucoma	☐	☐	☐
Thyroid Disorders	☐	☐	☐
Lung cancer	☐	☐	☐
Gastric cancer	☐	☐	☐
Colorectal cancer	☐	☐	☐
Breast cancer	☐	☐	☐
Cervical cancer	☐	☐	☐
Other cancers	☐	☐	☐

Site

☐ Other medical history (Previous treatments or hospitalizations)

2. Subjective symptoms (Have you had any symptoms of concern in the past year?)

None ☐

Headache ☐	Nausea/gastric pain ☐	Swelling of the body/face ☐
Numbness in the hands and feet ☐	Stomach ache ☐	Dizziness ☐
Hard to breathe ☐	Diarrhea ☐	Lost more than 3 kg ☐
Irregular pulse ☐	Constipation ☐	
Chest pain/tightness ☐	Bloody stools ☐	☐ Other symptoms
Cough/phlegm ☐	Thirsty ☐	
Heartburn / Belching ☐	Frequent urination ☐	
Difficult to swallow ☐	Difficulty urinating ☐	

3. Family History Do any of your parents or siblings have a history of the following diseases?

None ☐

High blood pressure ☐	Diabetes ☐	Gastric cancer ☐
Cerebrovascular disease ☐	Dyslipidemia ☐	Breast cancer ☐
Heart disease ☐	Lung cancer ☐	Other cancers ☐

4. Questions for those undergoing an abdominal exam

Do you have a Barium allergy?

Yes ☐ No ☐

Have you had surgery in the last 1 year?

Yes ☐ No ☐

5. Questions for women

Are you currently menstruating?

Yes ☐ No ☐

Are you/may be pregnant?

Pregnant ☐ Possibility ☐ No ☐

X-rays and waist circumference measurements will be

X-rays will be cancelled

6. Do you smoke?

Smoking more than 6 months or 100 cigarettes during life

Yes ☐ No ☐

☐☐ cigarettes/day Number of years ☐☐

Smoking in the last 1 month

Yes ☐ No ☐ → Stopped since ☐☐ Last year

Do you want to stop smoking?

Yes ☐ No ☐

7. Do you consume alcohol?

Don't drink ☐

Drink less than once a month, or have not drunk alcohol in the past year. ☐

Almost every day	☐
5-6 days per week	☐
1 week 3-4 times	☐
1 week 1-2 times	☐
1 month 1-3 times	☐
1 month rarely onc	☐
Quit drinking	☐

Amount per occasion

Less than 1 unit	☐
1 to less than 2 unit	☐
2 to less than 3 unit	☐
3 to less than 5 unit	☐
5 units or more	☐

Standard for 1 unit of Sake (approx. 15% alcohol, 180ml)

- Beer (5%・500ml)
- Shochu (25%・110ml)
- Wine (14%・180ml)
- Whisky (43%・60ml)
- Chu-hai can (5%・500ml. 7%・350ml)

8. Sports Habits・Eating・Lifestyle

Weight has increased by 10 kg or more since the age of 20.	Yes ☐	No ☐	
Walk faster than people of the same age and gender	Yes ☐	No ☐	
Exercise for at least 30 minutes per session (lightly sweating), at least twice a week, for over a year	Yes ☐	No ☐	
Engage in walking or equivalent physical activity for at least one hour per day in your daily life.	Yes ☐	No ☐	
Get sufficient rest through sleep	Yes ☐	No ☐	
Skipping breakfast 3 or more times a week	Yes ☐	No ☐	
Eat dinner within two hours before bedtime three or more times a week.	Yes ☐	No ☐	
How is your eating speed compared to that of others?	Fast ☐	Normal ☐	Slow ☐
Do you consume snacks or sugary drinks in addition to your three daily meals?	Every day ☐	Sometimes ☐	Rarely ☐
Have you ever received specific health guidance regarding lifestyle improvements?		Yes ☐	No ☐
Do you have any health-related concerns you would like to discuss?		Yes ☐	No ☐

Which of the following best describes your ability to chew your food?

Select one

- Can chew anything ☐
- I have some concerns with my teeth, gums, or bite, and sometimes find it difficult to chew. ☐
- Hardly able to chew ☐

Do you intend to improve your lifestyle habits, such as exercise and diet?

Select one

- No intention of making improvements. ☐
- Intend to make improvements (within the next 6 months). ☐
- Intend to make improvements soon (within the next month) and have already started taking small steps. ☐
- Already working on improvements (for less than 6 months). ☐
- Already working on improvements (for 6 months or more). ☐

9. Previous and Current Work Environments

Have you ever had experience handling heavy objects?	Yes ☐	No ☐
Have you ever had work experience involving the handling of dust?	Yes ☐	No ☐
Have you ever had work experience involving intense vibrations?	Yes ☐	No ☐
Have you ever had work experience involving the handling of hazardous substances?	Yes ☐	No ☐
Have you ever had work experience involving the handling of radiation?	Yes ☐	No ☐

What is your current work shift pattern?

Regular day shift ☐ Regular night shift ☐ Shift work (both day and night shifts) ☐ Not currently working ☐

What were your average daily working hours per week over the past month at your current workplace?

Less than 6 hours ☐ About 6-8 hours ☐ About 8-10 hours ☐ More than 10 hours ☐ Not currently working ☐

How many days per week did you work on average in the last month at your current workplace?

About 1-2 days ☐ About 3-5 days ☐ About 5 days ☐ More than 6 days ☐ Not currently working ☐