受診日(じゅしんび)

受付番号(うけつけばんごう)

Medical Consultation Form

胸部番号(きょうぶばんごう)

Please fill in the information below

name		sex	address
	Date of Birth: Y /M /D	male・female	〒 Tel ( )

※ If you are female, are you pregnant or is there any possibility of pregnancy? No ・ Yes

Your family's medical history	Have any of your relatives been affected by cancer? No ・ Yes	
	father mother brothers sisters	name of the disease
Your medical history	Have you had any of the conditions below? No ・ Yes (Please select from below if your answer is yes) Tuberculosis of the Lungs Pneumonia Pleurisy Asthma Silicosis Preumoconisis Heart Disease Gastritis Gastric ulcer Duodenal ulcer Gastrospasm Liver disease Cholecystitis Cholelithiasis Jaundice Nephrolithiasis Other( ) When did you have the condition? From M: Y: to M: Y: When did you receive the treatment? From M: Y: to M: Y: Have you had any operations? Yes age: name of the disease: No	
Smoking	Do you smoke? 1. Yes Since age ____ ____cigarettes a day 2. I used to smoke, but not anymore From ages____ to____ ____cigarettes a day 3. No	
Any current illness	No ・ Yes (name of the disease: since M: Y :)	

★ Do you agree to the privacy policy written on the back of this page? Yes ・ No

Respiratory screening questionnaire(lung cancer ・tuberculosis)

work experience	Have you ever worked in any of the work fields below? No ・ Yes (Please select from below if your answer is yes) welding quarry stonemasonry glass manufacture buildings with asbestos coal mine foundry pottery construction/demolition of buildings constructionwork garbage transfer shipcrew shipbuilding car mechanic chemicals textile industry Other( ) Period of time employed at the above workplace:
Any current symptoms	Answer the following 1. Cough persists for more than one month. ・・・・・・ No ・ Yes 2. Coughing up phlegm persists for more than one month. ・・・・・・ No ・ Yes 3. Blood is mixed with the phlegm ・・・・・・ No ・ Yes ↳ If yes … within the last 6 months ・・・・・・ No ・ Yes 4. Persistent chest pain. ・・・・・・ No ・ Yes 5. You feel winded or out-of-breath. ・・・・・・ No ・ Yes

Did you have an X-ray examination of the lungs last year? No ・ Yes → results(no abnormality ・ thorough examination needed)

Name of the institution you had the test at →(The Anti-Tuberculosis Association・other medical institution:)

言語(げんご)(英語(えいご))