

HEALTH CERTIFICATE (健康診断証明書)

Japanese Language Department
Tenrikyo Language Institute

Name of Applicant (氏名):	_____		
Date of Birth (生年月日):	____/____/____	Citizenship (国籍):	_____
Present Address (現住所):	_____		
Height (身長):	_____ cm	Weight (体重):	_____ kg
Sex (性別):	<input type="checkbox"/> Male (男)	<input type="checkbox"/> Female (女)	

1. MEDICAL HISTORY (病歴)

Please check the names of the diseases which you have ever contracted if any.

(下記の病気にかかったことがあれば病名の左の口に ✓ 印を記すこと)

- | | | |
|--|---|---|
| <input type="checkbox"/> Tuberculosis (結核) | <input type="checkbox"/> Poliomyelitis (小児マヒ) | <input type="checkbox"/> Jaundice (黄疸) |
| <input type="checkbox"/> Asthma (喘息) | <input type="checkbox"/> Neurosis (神経症) | <input type="checkbox"/> Anemia (貧血) |
| <input type="checkbox"/> Cardiac Disease (心疾患) | <input type="checkbox"/> Psychosis (精神病) | <input type="checkbox"/> Malnutrition (栄養障害) |
| <input type="checkbox"/> Renal Disease (腎疾患) | <input type="checkbox"/> Rheumatism (リウマチ) | <input type="checkbox"/> Major Trauma (大きな外傷) |
| <input type="checkbox"/> Epidemic or Endemic Disease (e.g., Malaria, Amebic dysentery) (伝染病、またはマラリア、アメーバ赤痢のような風土病) | | |
| <input type="checkbox"/> Others (他): _____ | | |

2. PHYSICAL FINDINGS (現症)

Vision (視力):	Right (右) _____	Left (左) _____
Color Sense (色覚):	_____	Eye Disease (眼疾): _____
Hearing (聴力):	_____	Ear Disease (耳疾): _____
Nose, Pharynx & Oral cavity (鼻, 咽喉及び口腔粘膜): _____		
Skin (皮膚):	_____	Lymphadenopathy (リンパ節腫張): _____
Lung (Describe X-ray Findings if any) (胸部X線検査): _____		

Heart (心臓):	_____	Abdomen (腹部): _____
Bones, Joints, Locomotor System (骨、関節、運動器官): _____		
Other Abnormal Findings (その他身体の異常): _____		

3. GENERAL STATUS : check one (上記のもの診断結果、健康状態は…である。)

- Excellent (優) Good (良) Fair (可) Poor (不良)

Name of Physician (医師の氏名):	_____
Name of Clinic (医療機関名):	_____
Address (住所):	_____
Date (診察日):	____/____/____
Signature of Physician (医師署名):	_____