

Cancer Examination Consultation Form

Control number

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※ We may contact you in an emergency, etc., so please provide a telephone number at which you can be easily contacted.																						
※ Age at end of coming March _____	Check items _____	Registration number _____																				
Date of birth	Individual number	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td><td style="width: 20px;">□</td> </tr> </table>	□	□	□	□	□	□	□	□	□	□										
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* Please complete the questionnaire in advance in pencil, and bring it with you on the day of the health check. Please be sure to submit it after taking the examinations.
 * This form will be processed by machine, so please do not bend it or make it dirty. If you will take the breast or cervical cancer examinations, please also complete the reverse side.

*From the following, please fill in your current and past medical history, and complete the questionnaire for the examinations you have applied to take (the items in the double frame marked with a star).
 Note: For items related to your physical condition, please mark with a line the option that applies to you for the most recent month.

<div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Medical history (present and past) for tuberculosis/Lung cancer examination ★ </div> <p><input type="checkbox"/> Nothing in particular</p> <table border="1" style="width: 100%; text-align: center; font-size: small;"> <thead> <tr> <th></th> <th>Being treated</th> <th>Healed</th> <th>Left</th> <th>Surgery</th> <th>Age</th> </tr> </thead> <tbody> <tr> <td>Pneumoconiosis</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Pulmonary tuberculosis</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Chronic bronchitis</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Pneumonia</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Pleuritis</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Asthma</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Lung cancer</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> <tr> <td>Other respiratory illness ()</td> <td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>□□</td> </tr> </tbody> </table>		Being treated	Healed	Left	Surgery	Age	Pneumoconiosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Pulmonary tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Pleuritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	Other respiratory illness ()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	□□	<div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Questionnaire for tuberculosis/lung cancer examination ★ </div> <p><input type="checkbox"/> Never smoked</p> <p><input type="checkbox"/> Currently smoke</p> <p><input type="checkbox"/> Previously smoked (years ago)</p> <p>Your smoking index is:</p> <table style="font-size: small;"> <tr> <td>□□□</td> <td>cigarettes /day</td> <td>×</td> <td>□□</td> <td>years</td> </tr> <tr> <td colspan="5">= Smoking index □□□□</td> </tr> </table> <p><input type="checkbox"/> ①Nothing in particular</p> <p><input type="checkbox"/> ②Pregnant (Possibly pregnant) <input type="checkbox"/></p> <p><input type="checkbox"/> ③Persistent chest pain</p> <p><input type="checkbox"/> ④Coughing/Phlegm</p> <p><input type="checkbox"/> ⑤Bloody phlegm within the last 6 months</p> <p><input type="checkbox"/> ⑥Have pneumoconiosis or have worked with asbestos</p>	□□□	cigarettes /day	×	□□	years	= Smoking index □□□□					<div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Lung cancer examination </div> <p><input type="checkbox"/> Lung cancer examination</p> <div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Tuberculosis examination </div> <p><input type="checkbox"/> Tuberculosis examination</p> <p>NO</p> <div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Sputum examination </div> <p><input type="checkbox"/> Sputum examination</p> <p>• Sputum examination not wanted</p> <p>• Sputum examination wanted</p> <p>Smoking index (600 or over) (Aged 50 or over)</p> <p>• Distributed</p>	<div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Stomach cancer examination </div> <p><input type="checkbox"/> Stomach cancer examination</p> <p>NO</p> <p>※ Larger amount of laxatives desired <input type="checkbox"/></p> <div style="border: 1px solid black; padding: 2px; background-color: #d9ead3;"> Colorectal cancer examination </div> <p><input type="checkbox"/> Colorectal cancer examination</p> <p>• 1 • 2</p>
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Quantity/Time</p> <p>• No • Yes → ()</p> <p>Have you had a gastrectomy? Range removed</p> <p>• No • Yes → ()</p> <p>Do you have a barium allergy?</p> <p>• No • Yes [No exam.] <input type="checkbox"/> 1st time</p> <p>Do you have colonic diverticulitis? Explanation <input type="checkbox"/></p> <p>• No • Yes [No exam.]</p> <p>Do you have a brain disease? () Medical history after onset of brain disease</p> <p>• No • Yes → • No • Yes</p> <p>Have you ever been told you have high blood pressure?</p> <p>• No • Yes →</p> <table style="font-size: small;"> <tr> <td style="border: 1px solid black; padding: 2px;">Normal blood pressure ()</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Treatment for blood pressure</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">• No • Yes</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Blood pressure today (to be filled in by staff) (/)</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">Internal medicine today</td> </tr> <tr> <td style="border: 1px solid black; padding: 2px;">• No • Yes</td> </tr> </table>	Normal blood pressure ()	Treatment for blood pressure	• No • Yes	Blood pressure today (to be filled in by staff) (/)	Internal medicine today	• No • Yes
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Staff comments (Stamp)
