

# Cancer Examination Consultation Form がん検診受診票

					T E L Check items	※ We may contact you in an emergency, etc., so please provide a telephone number at which you can be easily contacted.					I D										
															Registration number						
※ Age at end of coming March					Check type	Individual number	Group														
Date of birth	Age	Sex																			
Date of Check	Site																				

\* 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.

Medical history (present and past) for tuberculosis/Lung cancer examination					Questionnaire for tuberculosis/lung cancer examination	Lung cancer examination					Stomach cancer examination																																																					
<input type="checkbox"/> Nothing in particular <table border="1"> <tr> <td>Being treated</td> <td>Healed</td> <td>Left</td> <td>Surgery</td> <td>Age</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Pneumoconiosis</td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Pulmonary tuberculosis</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Chronic bronchitis</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Pneumonia</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Pleuritis</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Asthma</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Lung cancer</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> <tr> <td>Other respiratory illness( )</td> <td> </td> <td> </td> <td> </td> <td>88</td> </tr> </table>					Being treated	Healed	Left	Surgery	Age					88	Pneumoconiosis					Pulmonary tuberculosis				88	Chronic bronchitis				88	Pneumonia				88	Pleuritis				88	Asthma				88	Lung cancer				88	Other respiratory illness( )				88	<input type="checkbox"/> Never smoked <input type="checkbox"/> Currently smoke <input type="checkbox"/> Previously smoked(      years ago) Your smoking index is: 888 cigarettes /day × 88 years = Smoking index 8888 <input type="checkbox"/> ①Nothing in particular <input type="checkbox"/> ②Pregnant (Possibly pregnant) <input type="checkbox"/> <input type="checkbox"/> ③Persistent chest pain <input type="checkbox"/> ④Coughing/Phlegm <input type="checkbox"/> ⑤Bloody phlegm within the last 6 months <input type="checkbox"/> ⑥Have pneumoconiosis or have worked with asbestos					<input type="checkbox"/> Lung cancer examination <input type="checkbox"/> Tuberculosis examination  NO  <input type="checkbox"/> Sputum examination <ul style="list-style-type: none"> <li>▪ Sputum examination not wanted</li> <li>▪ Sputum examination wanted</li> <li>Smoking index (600 or over)</li> <li>(Aged 50 or over)</li> <li>▪ Distributed</li> </ul> <input type="checkbox"/> Stomach cancer examination  NO  <input type="checkbox"/> Colorectal cancer examination <ul style="list-style-type: none"> <li>▪ 1</li> <li>▪ 2</li> </ul>				
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					Lung cancer examination history											
					<input type="checkbox"/> No	<input type="checkbox"/> Yes										

Medical history (present and past) for stomach cancer/colorectal cancer examination					Questionnaire for stomach cancer/colorectal cancer examination	Questionnaire for stomach cancer examination																																																										
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Staff comments (Stamp)									
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Questionnaire for cervical cancer/breast cancer examination ★

## 1) Family history

 Nothing in particular

① Breast cancer    ② Cervical cancer    ③ Endometrial cancer

Mother Sister Grandmother 

## 2) Pregnant/Possibly pregnant

 No YesMedical history (present and past) for cervical cancer ★ Nothing in particular    ※ Surgical history (excluding Caesarean section)

	Being treated	Cured	Left	Surgery	Age
Uterine fibroid	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Uterine cancer	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Vaginal erosion	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Vaginitis	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Polyps	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Endometriosis	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Adenomyosis of the uterus	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Ectopic pregnancy	<input type="checkbox"/> 8 <input type="checkbox"/> 8				

Ovarian cyst (L + R)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Salpingitis (R + L)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				

Other gynecological diseases ( )	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
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Cervical cancer examination history	<input type="checkbox"/> No	<input type="checkbox"/> Yes	→	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormalities
	<input type="checkbox"/> Explanation	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Medical history (present and past) for breast cancer ★ Nothing in particular

	Being treated	Cured	Left	Surgery	Age
Mastitis (R + L)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Mammary gland disease (R + L)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Fibroadenoma (R + L)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
Breast cancer (R + L)	<input type="checkbox"/> 8 <input type="checkbox"/> 8				

Range removed → ( )

Other breast diseases ( )	<input type="checkbox"/> 8 <input type="checkbox"/> 8				
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Breast cancer examination history  No  YesQuestionnaire for cervical cancer examination ★1) Menopause age  8  8 years

## 2) Last menstruation

※ If you are post-menopausal, this does not need to be completed.

From ( ) Y ( ) M ( ) D for ( ) day

Menstruation  Regular ( ) day type  IrregularMenstrual flow  Small amount  Normal  Large amountMenstrual pain  No  Yes

## 3) Pregnancy and delivery (if none, please write 0)

Pregnancies  8  8 times Spontaneous miscarriages  8  8 timesDeliveries  8  8 times Artificial abortions  8  8 times

## 4) Have had a Caesarean section

 No  Yes ( ) times

## 5) Other questions

 ① Nothing in particular ② Feel swollen in the lower abdomen ③ Itching in the genital area ④ Have vaginal discharge

[ Small amount    Large amount ]

[ Whitish    Yellowish ]

 ⑤ Have irregular bleeding

[ Small amount    Large amount ]

[ Fresh blood    Brownish    Weak ]

## Sexual experience

 No  Yes

## Using hormones

 No  Yes

## HPV vaccination history (cervical cancer vaccine)

 No  Yes

Last vaccination date ( ) Y ( ) M

( ) doses

## Breast cancer examination

1-R  2-R 

NO

## Cervical cancer examination

 (Age 20 and over)

NO

## To be filled in by a doctor

## Vaginal erosion

## Uterine fibroid

 Possible  Definite Possible  Definite

## Vaginitis

## R ovarian cyst

 Possible  Definite Possible  Definite

## Cervical polyps

## L ovarian cyst

 Possible  Definite Possible  Definite

## Other

Reflection of results ( No • Needed )

## Judgement

 Normal Follow-up Needs treatment  
(Needs medical care)

## Doctor NO

 8  8  8

## Staff comments

Questionnaire for breast cancer examination ★

## 1) Any symptoms you are aware of

 ① Nothing in particular ② Have pain in the breast(s)(  ③ R  ④ L  ⑤ Both ) ⑥ Have a lump in the breast(s)(  ⑦ R  ⑧ L  ⑨ Both ) ⑩ Have nipple discharge

## 2) Have a pacemaker

 No  Yes

## 3) Have had breast augmentation surgery

 No  Yes

## 4) Breastfeeding history

 No  Yes

## 5) Currently breastfeeding

• Yes

※ Including if the child was weaned within the last month