

How to Fill in the OCR

= Advice to All Who Are Going to Receive the Health Checkup =

= Please follow the instructions given below! =

- Enter your responses using a **black pencil** or **mechanical pencil** (**ball-point pen is unacceptable**); see the examples below.
- This OCR sheet will be mechanically read. Do not bend it or expose it to water or dirt.

{ [Examples of entering numerals]

™ © Good entry

- × Bad entry
- Adding a hook
 - Adding a loop
 - May be mistaken read as "9" ⇒
 - Uncertain as to which of "0" or "6" is meant
 - Exceeding the space for entry
 - Do not join the two upper vertical lines while extending the horizontal line to the right

{ [Examples of entering marks]

™ © Good entry or

- × Bad entry
- Encircling the frame
 - Too small
 - Exceeding the space for entry

{ [Other points requiring care]

Age : (month) (day) ⇒ Add "0" before one-digit number

[Please ensure that you have answered all the questions!]

If your responses to the questionnaire are incomplete, you will have to sit for an inquiry on the date of the health checkup.

In such cases, the time taken for the checkup will be longer than usual. Please understand it.

Name:

years old

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Questionnaire

5. Family history

Do any of your blood relatives (parents, grandparents, brothers/sisters and so on) have a history of the following illnesses?

Table with columns: Hypertension, Diabetes mellitus, Angina pectoris/Myocardial infarction, Stroke, Unexplained sudden death, Glaucoma, Cancer, and Site: (). Rows: Father, Mother, Grandparent, Brother/Sister.

6. Were you found to have any abnormality (requiring re-test or detailed test) at a previous health checkup performed within the previous 3 years (including checkup at other facilities); if so, please mention the abnormality and the results of the re-test or detailed test.

Table with columns: Abnormality found, Re-test/detailed test results (please encircle the relevant alternative), and In other cases, enter the outcome in the parentheses.

7. Inquiry about endoscopy

Have you undergone gastric endoscopy within the previous one year?

No Yes If "Yes," please enter the endoscopy results. ()

Have you undergone colorectal endoscopy within the previous 2 years?

No Yes If "Yes," please enter the endoscopy results. () When was the colorectal endoscopy performed? (year month) Approximate or incomplete answer will also suffice.

8. Inquiry about subjective symptoms

Please check the symptoms you have now or have experienced during the previous one year.

None If you have not had any of the symptoms listed below, please check the box against "None." List of symptoms: Heartburn, Gastric discomfort, Stomachache, Nausea, Difficulty in swallowing, Frequent cough, Frequent sputum, Chest pain, Tightness of the chest, Arrhythmia, Palpitation, Shortness of breath, Headache, Dizziness/lightheadedness, Malaise, Bleeding during evacuation, Pain during urination, Residual urine sensation, Difficulty in urination, Loss of consciousness experienced within the previous one year.

9. Please check the appropriate box describing your job. *If your job does not fall under any of those listed below, please enter your occupation in the column of "Others."

Administrative position, Teacher, Sales, Clerk, Jobless/Retired upon reaching the age limit, Physician, Self-employed, Housewife, Others ()

Name:

years old

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Questionnaire

10. Inquiry about your lifestyle

Please check the relevant alternatives or enter numeral:

• Do you smoke habitually?

No, I don't smoke

Yes, I smoke.

I have stopped smoking.

(years ago)

If you are a smoker or ex-smoker, please enter the number of cigarettes that you smoke/smoked daily and the duration of smoking.

Daily cigarettes ca. years

• Please enter the frequency of your drinking alcohol.

(1) Every day

(2) Sometimes

(3) Having stopped drinking

Seldom (unable to drink)

(years ago)

[If you have checked (1), (2) or (3):]

Please answer the volume of alcohol consumed on a typical drinking day.

Less than 1 Go

1 to less than 2 Go

2 to less than 3 Go

3 Go or more

*Japanese wine 1 Go (180 mL) is approximately equivalent to: beer 500 mL, Shochu (25%) 110 mL, one double-glass of whisky (60 mL), two glasses of wine (240 mL)

On how many days of the week do you drink alcohol? (if your answer is (3), on how many days of the week did you used to drink?) days

• Have you lost weight by 3 kg or more during the previous 1 year?

No

Yes

If "Yes," please give the reason for the weight loss of 3 kg or more.

Diet therapy or exercise

Reason unknown

Other reasons ()

• Have you gained weight by 10 kg or more as compared to your weight recorded when you were 20 years old?

No

Yes

• Have you been exercising (for 30 minutes or more, until you sweat lightly) on 2 days or more of the week for one year or longer?

No

Yes

• Do you walk or engage in similar physical activity for one hour or more per day in your daily life?

No

Yes

• Do you walk faster than people of the same age and gender as you?

No

Yes

• Please select the style of eating food from the alternatives given below.

Check one alternative.

I can chew/eat any food.

I can hardly chew food.

I sometimes have difficulty in chewing food because of problems with my teeth, gums, occlusion or the like.

• How about your speed of eating as compared to other people?

Faster

Normal

Slower

• Do you take your supper within 2 hours of your bedtime thrice or more per week?

No

Yes

• Do you take snack or sweet beverage in addition to three meals (breakfast, lunch and supper)?

Every day

Sometime

Seldom

• Do you skip breakfast three times or more per week?

No

Yes

• On how many days of the week do you eat fish?

days

• Do you intend to improve your lifestyle (exercise, dietary style, etc.)?

Check one alternative.

No intention to improve my lifestyle

Already begun to improve my lifestyle (less than 6 months ago)

Intend to improve my lifestyle (within the next about 6 months)

Already begun to improve my lifestyle (since 6 months ago or more)

Intend to improve my lifestyle soon (within about 1 month) and have begun to take small steps in that direction

• If you are given the opportunity to receive health guidance for improvement of your lifestyle, will you utilize it?

No

Yes

• Do you feel sufficiently refreshed after a night of sleep?

No

Yes

• How many hours do you sleep daily, on average?

hours

Name:

years old

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Questionnaire

Questions for women only

1. Inquiry to judge the appropriateness of conducting radiography. Please check the relevant alternative or enter a numeral.

I am definitely not pregnant now. I may be pregnant now (or, I am not sure if I am pregnant). I am pregnant () months of pregnancy

*If you have answered "I may be pregnant now (or, I am not sure if I am pregnant)" or "I am pregnant," you cannot undergo any radiographic examination.

2. Inquiry about menstruation. Please check the relevant alternative.

Are you currently menstruating? No Yes

*If you are currently menstruating, it can affect the results of your urine test. We recommend that you postpone your health checkup to a time when you are not menstruating.

Inquiry for those who desire to undergo a breast examination. Please check the relevant alternative.

1. Receiving outpatient care for breast disease at present No Yes ()

*Receiving doctor's care through periodic visits to a hospital

2. Breastfeeding at present No Yes

3. I weaned my infant off breast milk recently (within the previous 6 months). No Yes

4. Currently receiving augmentation mammoplasty (injection, etc.) No Yes

5. I have an implanted cardiac pacemaker. No Yes

6. I have an encephalo-peritoneal shunt. No Yes

Diagnosis

- Currently receiving treatment for breast cancer or visiting a hospital for outpatient care
• Underwent surgery for breast cancer less than 6 years ago
• Breastfeeding at present
• Recently weaned infant off breast milk (within the previous 6 months)
• Pregnant at present
• Receiving augmentation mammoplasty

Breast examination will not be

7. Family history: Do any of your blood relatives (grandparents, parents, brothers/sisters, children) have a history of any of the illnesses listed below?

Breast cancer (Who) Ovarian cancer (Who) Prostate cancer (Who) Other cancer (Site: Who:)

8. I have undergone surgery for breast cancer. No Yes (right left)

I have undergone surgery for breast illness (benign). No Yes (right left)

Inquiry for those who desire to undergo gynecological examination. Please check the relevant alternative or enter a numeral.

*The gynecological test cannot be received during the menstruation period. If you are during menstruation, please change the schedule.

1. Currently receiving outpatient care for gynecological disease No Yes ()

*Receiving doctor's care through periodic visits to a hospital

2. I have undergone gynecological surgery. No Yes (Please enter the operation you have received)

3. I have a history of pregnancy. No Yes (Frequency of delivery times) *If you have been pregnant before, please enter your 'para' status.

4. Experience of sexual intercourse Absent Present

5. Menstrual cycle Regular Irregular Menopause (at age)

6. Last menstrual period (month) (day), started days

7. Menstrual pain Absent Present

8. Menstrual blood loss Small Ordinary Large

*If you are postmenopausal, you may skip questions 6 through 8.

To those who desire to undergo a thorough health checkup (who have received a container for bringing a stool sample)

The stool test is designed to check for blood contained in the feces. If you collect a stool sample during menstruation, the fecal sample may test positive for occult blood (false positive result).

Please collect the stool sample when you are not menstruating. Please submit the stool sample within 5 days after collection.

If you cannot submit your stool sample within 5 days after collection, you may submit the sample by postal service. Please inform our reception desk about

