Medical Check Sheet (No health insurance available in case of any disease)

Your name			Male / Female	Training course	

1. Complete all the boxes from a. to k., please tick with V mark in the appropriate answer box and parenthesis.

	Yes	No	Condition
a.			( ) Asthma, ( ) emphysema, ( ) or other lung conditions
b.			( ) Tuberculosis, ( ) or live with anyone who has tuberculosis
c.			( ) High blood pressure (*1), ( ) heart disease, ( ) irregular heartbeat
d.			( ) Stomach ulcer, ( ) hepatitis, ( ) inflammation of the gallbladder, ( ) gallstones, pancreatitis
e.			( ) Kidney trouble, ( ) bladder trouble, ( ) stones in urine, ( ) blood in urine
f.			( ) Diabetes (*2), ( ) gout
g.			( ) Depression, ( ) neurosis
h.			( ) Tumor, ( ) malignant tumor, ( ) cancer
i.			( ) Bleeding disorder, ( ) blood disease
j.			( ) Lumbago
k.			( ) Cataract, ( ) glaucoma

2. Please tick with V mark in the appropriate answer box and give details.

	Medical History	Yes	No	Details (diagnostic data if needed)
a.	Have you had any significant or serious illness or injury? (If hospitalized or had operation, give places & dates.)			
b.	Do you currently use any drugs for treatment of a medical condition? (Give name & dosage.)			*1 (High mmHg / Low mmHg) *2 (HbA1C: , FBS:)
c.	Are you seriously allergic to foods, medicine, substances or others?			

3. I certify that I have read the above instructions and answered all questions truly and completely to the best of my knowledge.

Your Signature _____ Date : Day / Month /Year

※ If you answered [Yes] to any one of the items listed above in 1 or 2, please see a doctor for an up-to-date medical examination.

〔For doctor use〕

In response to the claim of the individual whose signature appears above, you are requested to provide us with your observations in the following two sections.

I. Please write the results of the medical examination with diagnostic data.

Name of hospital:

Date of diagnosis:

Address:

Name of the doctor:

Doctor's Signature: