健 康 診 断 書

CERTIFICATE OF HEALTH

(to be filled out by a physician)

NAME OF APPLICANT (in English block capitals)	SEX M F	AGE	DATE OF BIRTH
PRESENT ADDRESS			

1. Height_____ cm. Weight_____ kg.

   Blood pressure: Sys._____ Dia._____ Pulse rate_____/m Reg. Irreg.

   Reflexes: Pupil; Normal Abnormal Knee; Normal Abnormal Others( ); Normal Abnormal

Eye-sight:	Left	Right	Color-blindness	Hearing
without glasses			Yes;( )	Left ;_____
(with glasses)	( )	( )	No	Right;_____

2. Anamnesis: Please check any that apply

   Tuberculosis ☐ Malaria ☐ Rheumatic fever ☐ Epilepsy ☐ Kidney disease ☐

   Cardiac diseases ☐ Diabetes ☐ Allergy ☐ Other diseases ☐

3. Present conditions: Please check any that apply

   Tonsils, nose or throat ☐ Heart or blood vessels ☐ Lungs or respiratory system ☐

   Stomach or digestive ☐ Genito-urinary system ☐ Other abdominal organs ☐

   Brain or nervous system ☐ Blood or endocrine system ☐ Bones, joints or locomotor system ☐

   Skin ☐ Venereal disease ☐

4. If you checked anything in 2 or 3 above, please describe each in detail. If the applicant is physically handicapped, describe the abnormality or impairment.

5. Applicant's lungs: (Condition, including the data and results of a Chest X-ray.)

6. History (if any) of a nervous or mental disorder.

7. History of diseases; malaria, dysentery, polio, measles, mumps, etc.

8. In my opinion, the applicant's health and physical condition is: (Please check one)
   Excellent Good Fair Poor

9. In my opinion, the applicant is physically able to go abroad for study: (Please check) Yes_____ No_____

NAME & TITLE OF PHYSICIAN (English block capitals) _____

ADDRESS _____

SIGNATURE _____

DATE _____

day / month / year