

# CERTIFICATE OF HEALTH (to be completed by the examining physician)

Please fill out (PRINT / TYPE) in English.

Name : \_\_\_\_\_ , \_\_\_\_\_  Male  Female Date of Birth : \_\_\_\_\_ Age : \_\_\_\_\_  
Family name                      First name                      Middle name

1. Physical Examinations

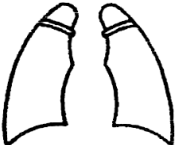
- (1) Height \_\_\_\_\_ cm                      Weight \_\_\_\_\_ kg
- (2) Blood pressure \_\_\_\_\_ mm/Hg~\_\_\_\_\_ mm/Hg      Blood Type 

A	B	O
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RH	+	-
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      Pulse  regular  irregular
- (3) Eyesight : (R) \_\_\_\_\_ (L) \_\_\_\_\_      (R) \_\_\_\_\_ (L) \_\_\_\_\_      color blindness  normal  impaired  
without glasses                      with glasses or contact lenses
- (4) Hearing:  normal  impaired                      Speech:  normal  impaired

2. Please describe the results of physical and X-ray examinations of applicant's chest X-ray (X-ray taken more than 6 months prior to the certification is NOT valid).



Lung :  normal  impaired

Cardiomegaly :  normal  impaired

Electrocardiograph :  normal  impaired

←Date \_\_\_\_\_  
 Film No. \_\_\_\_\_

Describe the condition of applicant's lung.

3. Disease treated at present       Yes (Disease : \_\_\_\_\_ )  
 No

4. Past history : Please indicate with + or - and fill in the date of recovery

Tuberculosis..... ( . . . )      Malaria..... ( . . . )      Other communicable disease..... ( . . . )  
 Epilepsy..... ( . . . )      Kidney Disease..... ( . . . )      Heart Diseases..... ( . . . )  
 Diabetes..... ( . . . )      Drug Allergy..... ( . . . )      Psychosis..... ( . . . )  
 Functional disorder in extremities... ( . . . )

5. Laboratory tests

Urinalysis : glucose ( \_\_\_\_\_ ), protein ( \_\_\_\_\_ ), occult blood ( \_\_\_\_\_ )  
 ESR : \_\_\_\_\_ mm/Hr, WBC count : \_\_\_\_\_ /cmm      anemia   
 Hemoglobin : \_\_\_\_\_ gm/dl, GPT : \_\_\_\_\_

6. Please describe your impression.

7. In view of the applicant's history and the above findings, is it your observation that his/her health status is adequate to pursue intended study in Japan?  
yes       no

Date : \_\_\_\_\_ Signature : \_\_\_\_\_

Physician's Name in Print : \_\_\_\_\_

Office/Institution :

Address : \_\_\_\_\_