# MEDICAL EXAMINATION

| | Surname(Family Name) | Given Name | Middle Name |
|---|---|---|---|
| 1. Full Name | | | |

| | | | | | |
|---|---|---|---|---|---|
| 2. Examination Date | Month | Date | Year | 5. Sex | ☐ male ☐ female |
| | | | | 6. Height | cm |
| 3. Birthday | | | | 7. Weight | Kg |
| 4. Age | years | | | 8. Blood Pressure | mmHg |

9. Electrocardiogram(ECG)

☐ normal ☐ abnormal ( Comments:

10. Urinalysis

- Protein ☐ negative ☐ positive( Comments:
- Sugar ☐ negative ☐ positive ( Comments:
- Blood ☐ negative ☐ positive ( Comments:
- Others ( Comments:

11. Eyesight

- Right _____._____ (_____._____), - Left _____._____ ( ____._____)
- Color vision ☐ normal ☐ abnormal ( Comments:

12. Chest X-Ray

☐ normal ☐ abnormal ( Comments:

13. Blood

Anemia
WBC ( )
Hb ( )
RBC ( )

Liver Function
SGOT ( )
SGTP ( )
γ-GTP ( )

Blood Lipid
Total Cholesterol ( )
TRIG ( )

HbsAg ( )

Blood Type ( )

☐ normal

☐ abnormal (Comments:

14. Hearing

Right
1000Hz ☐ normal ☐ abnormal
4000Hz ☐ normal ☐ abnormal

Left
1000Hz ☐ normal ☐ abnormal
4000Hz ☐ normal ☐ abnormal

☐ normal

☐ abnormal (Comments:

15. Internal check

☐ normal ☐ abnormal (Comments:

16. General (Major illness, operation, allergies, broken bones, disabilities, etc.)

17. Is this person suffering from an illness at the time of this examination?
If so, specify nature and length of illness.

| | | |
|---|---|---|
| Name of Hospital | | |
| Address | TEL: FAX: | |
| Physician's Name | | Official Seal |
| Signature | | |
| Title | | |
| Date | year / month / date . | |