

National Health Insurance

Health Examination Ticket Number		Notification Number	
Name (in kana)			
Age	y/o <small>(Age as of 2027/03/31)</small>	Sex	
Date of Birth			
Valid until			

Toyoashi National Health Insurance Specific Health Checkup Ticket for the 2026 Fiscal Year

Issued

• Please read "Specific/General Health Checkup Information" for the 2026 Fiscal Year included in the same envelope.

• Please bring the following with you:

Specific Health Checkup Ticket

Something to confirm enrollment in Toyoashi City National Health Insurance (My Number card linked to your health insurance, "Health Insurance Qualification Confirmation Form" (資格確認書, shikaku kakunin-sho))

* If you will be having a combined Ningen Doc exam (included JA Toyoashi Ningen Doc exams) or receiving your checkup together with a group, you may have to bring different documents, etc.

※Please check the period of validity on this ticket above.

Outpatients currently receiving treatment can also be examined.

• Filling out your health checkup ticket:

Please fill out the questionnaire on the back of this paper. If you will be receiving your checkup together with a group, you only need to write your phone number(s) on the back of this page. You don't need to fill in the other fields.

※For clinic/medical institution use only. 以下は健診機関で記入します。

Exam Date	<input type="text"/> / <input type="text"/> Mo. <input type="text"/> / <input type="text"/> Day	National Health Insurance Card Number	<input type="text"/>
Body Measurements	Height: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm Weight: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kg BMI: <input type="text"/> <input type="text"/> <input type="text"/> AC (abdominal circumference): <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm		
Objective Symptoms	No: <input type="checkbox"/> Yes: <input type="checkbox"/>	Blood Pressure	SBP: <input type="text"/> <input type="text"/> <input type="text"/> / DBP: <input type="text"/> <input type="text"/> <input type="text"/> mmHg
Urinalysis	Protein: <input type="checkbox"/> - <input type="checkbox"/> ± <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++	Sugar: <input type="checkbox"/> - <input type="checkbox"/> ± <input type="checkbox"/> + <input type="checkbox"/> ++ <input type="checkbox"/> +++	Period: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Detailed Health Examinations	Anemia	Past history: <input type="checkbox"/> Potential: <input type="checkbox"/>	
	Electro-cardiogram	Blood pressure: <input type="checkbox"/> Individuals whose SBP was 140 mmHg and over/DBP was 90 mmHg and over in the current year's checkup results.	Potential arrhythmia: <input type="checkbox"/>
	Eye Fundus	Blood pressure: <input type="checkbox"/> Individuals whose SBP was 140 mmHg and over/DBP was 90 mmHg and over in the current year's checkup results.	Blood sugar: <input type="checkbox"/> Individuals whose blood sugar was 126mg/dℓ or over with an empty stomach, or individuals with an HbA1c (NGSP) of 6.5% and over, or those whose blood sugar is at or above 126mg/dℓ at all times. (For individuals who received their checkup at a medical institution, refer to this year's checkup results. For individuals who did their checkup with a group, refer to last year's checkup results.)
	Anemia: No <input type="checkbox"/> Yes <input type="checkbox"/>	Electro-cardiogram: No <input type="checkbox"/> Yes <input type="checkbox"/>	Eye Fundus: No <input type="checkbox"/> Yes <input type="checkbox"/>
	Name of requested clinic: <input type="text"/>	Code: <input type="text"/>	
Observations	Electro-cardiogram	Code: <input type="text"/>	Eye Fundus: <input type="text"/>
	Necessary to recommend follow-up exams?	No: <input type="checkbox"/> Yes: <input type="checkbox"/>	Scheie Classification: S0 <input type="checkbox"/> S1 <input type="checkbox"/> S2 <input type="checkbox"/> S3 <input type="checkbox"/> S4 <input type="checkbox"/> H0 <input type="checkbox"/> H1 <input type="checkbox"/> H2 <input type="checkbox"/> H3 <input type="checkbox"/> H4 <input type="checkbox"/>
	BP: <input type="checkbox"/> 1 <input type="checkbox"/> Fats: <input type="checkbox"/> 2 <input type="checkbox"/> BG: <input type="checkbox"/> 3 <input type="checkbox"/> Liver: <input type="checkbox"/> 4 <input type="checkbox"/> Kidney: <input type="checkbox"/> 5 <input type="checkbox"/> UA: <input type="checkbox"/> 6 <input type="checkbox"/> Anemia: <input type="checkbox"/> 7 <input type="checkbox"/> ECG: <input type="checkbox"/> 8 <input type="checkbox"/> FO: <input type="checkbox"/> 9 <input type="checkbox"/> Other: <input type="checkbox"/>		
Clinic Name 医院名		Clinic Code 医院コード	Physician Name 医師氏名: <input type="text"/>
			Class 種別: 国保 61

■ For patient use (Please fill out the following information).

Information may be used for health services, such as sending SMS messages to cell phone numbers to recommend health checkups, etc.

Phone Number (Cell)	[] [] [] - [] [] [] [] - [] [] [] []			Phone Number (Home)	[] [] [] [] - [] [] [] [] - [] [] [] []							
1	Do you use any of the following medicines (1 - 3) regularly?				Please draw a diagonal line (/) through the applicable box							
5	1	Medicine to lower blood pressure?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
3	2	Medicine or insulin injections to lower blood sugar levels?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
	3	Medicine to lower cholesterol or neutral fats/triglycerides?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No						
4	Have you been told by a doctor that you suffered/are suffering from a stroke (cerebral hemorrhage, cerebral infarction, etc.) or have received treatment for a stroke?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
5	Have you been told by a doctor that you suffered/are suffering from heart disease (angina pectoris, myocardial infarction/heart attack, etc.) or have received treatment for heart disease?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
6	Have you been told by a doctor that you are suffering from chronic kidney disease or kidney failure, or have received treatment (dialysis, etc.) for chronic kidney disease or kidney failure?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
7	Have you ever been told by a doctor that you are anemic?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
8	Are you currently a habitual smoker? Condition 1: You've smoked for at least 1 month recently Condition 2: You've smoked for a period of 6 months or more at some point in your life and/or have smoked at least 100 combined cigarettes in your life.		① Both 1 and 2 apply ② Only 2 applies ③ I don't smoke Or neither ① nor ② applies		<input type="checkbox"/>	①	<input type="checkbox"/>	②	<input type="checkbox"/>	③		
9	Have you gained 10kg or more since turning 20?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
10	Have you been doing light exercise for at least 30 minutes twice or more per week for one year or longer?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
11	Have you been walking for at least one hour during your daily activities or doing physical activity equivalent to walking for at least one hour daily?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
12	Do you tend to walk faster than those of the same gender and the age as you?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
13	Which of the following best applies to you when chewing food?		① I can eat and chew all kinds of food. ② I am concerned about my teeth, gums, or bite, and it is sometimes difficult to chew food. ③ I cannot chew most foods.		<input type="checkbox"/>	①	<input type="checkbox"/>	②	<input type="checkbox"/>	③		
14	Do you tend to eat more quickly than others?				<input type="checkbox"/>	Fast	<input type="checkbox"/>	Normal	<input type="checkbox"/>	Slow		
15	In a one week period, do you eat dinner within 2 hours of going to bed three or more times?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
16	Do you have snack or sugary drinks in between proper meals (breakfast, lunch, and dinner)?				<input type="checkbox"/>	Daily	<input type="checkbox"/>	Once in a while	<input type="checkbox"/>	Almost never		
17	Do you skip breakfast 3 or more times in a week?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
18	How often do you drink alcohol (sake, shōchū, beer, hard alcohol, etc.)? (Please select only one answer) *("Quit" means you have not consumed alcoholic beverages in at least 1 year after habitually drinking at least once/month in the past)				<input type="checkbox"/>	Daily	<input type="checkbox"/>	5-6 days a week	<input type="checkbox"/>	3-4 days a week	<input type="checkbox"/>	1-2 days a week
					<input type="checkbox"/>	1-3 days a month	<input type="checkbox"/>	Less than once/month	<input type="checkbox"/>	I quit	<input type="checkbox"/>	Don't drink/can't drink
19	On days that you drink alcohol, how many alcoholic drinks do you drink? (Please select only one answer) A one-drink measurement is based on one "gou," or 180ml, of 15% alcohol sake, which is also approximately: One 500ml bottle of beer (5% alcohol), 110ml of shōchū (25%), 180ml of wine (14%), one double-shot (60ml) of whisky (43%), or a 500ml (5%) or 350ml (7%) can of chūhai.				<input type="checkbox"/>	Less than 1 drink	<input type="checkbox"/>	1-2 drinks	<input type="checkbox"/>	2-3 drinks		
					<input type="checkbox"/>	3-5 drinks	<input type="checkbox"/>	5 or more drinks				
20	Do you feel well-rested after sleeping?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
21	Do you want to improve your current lifestyle (exercise, eating habits, etc.)? Please choose one from ① to ⑤		①No, I'm not planning on it. ②Yes, within the next six months. ③Yes, within the next month, and I am already slowly improving my lifestyle.		④I have already begun improving my lifestyle (within the past six months). ⑤I have already begun improving my lifestyle (for six months or more).		<input type="checkbox"/>	①	<input type="checkbox"/>	②	<input type="checkbox"/>	③
					<input type="checkbox"/>	④	<input type="checkbox"/>	⑤				
22	Have you ever received health guidance related to lifestyle improvement?				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
23	When was the last time you ate a meal?				<input type="checkbox"/>	Within 3.5 hrs	<input type="checkbox"/>	3.5 - 10 hrs ago	<input type="checkbox"/>	10+ hrs ago		
24	Subjective symptoms		<input type="checkbox"/> 1 None <input type="checkbox"/> 2 Headache <input type="checkbox"/> 3 Dizziness <input type="checkbox"/> 4 Ringing in ears <input type="checkbox"/> 5 Chest pain <input type="checkbox"/> 6 Heart palpitations <input type="checkbox"/> 7 Dry mouth <input type="checkbox"/> 8 Sudden weight loss <input type="checkbox"/> 9 Swelling <input type="checkbox"/> 10 Get tired easily <input type="checkbox"/> 11 Numbness in hands/feet <input type="checkbox"/> 12 Others ()									
25	What made you decide to take Specific Health Checkup (multiple answers possible)		<input type="checkbox"/> 1 I have a checkup every year <input type="checkbox"/> 2 I have received a ticket <input type="checkbox"/> 3 I have received information by post or SMS <input type="checkbox"/> 4 I have seen the information on posters and <input type="checkbox"/> 5 My doctor's recommendation <input type="checkbox"/> 6 My close friends' and family members' recommendation <input type="checkbox"/> 7 concerns on my health <input type="checkbox"/> 8 I have confidence in my health. <input type="checkbox"/> 9 Others ()									

Insurer	Address	1 Imahashicho, Toyohashi, Aichi
	Telephone	0532 - 51 - 2293
	Insurer Number	00230029
	Insurer Name	Toyohashi City
Payment Agency Number		92399021
Payment Agency Name		Aichi Prefecture National Health Insurance Federation

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