

※Please bring this form and the other contents of the letter including the envelope with you.

2021 Toyohashi-city

Respiratory (Tuberculosis/Lung Cancer) Questionnaire 令和3年度(2021年)肺(結核・肺がん)検診票

Page5

1	Have you received the lung examination in the past?	No	Yes	Year taken: <input type="text"/> Year Place received: () Results of previous exam: Normal • Abnormal/No follow-up exam • Follow-up exam needed (examination required abnormal findings Y/N)	6	Symptoms		No	Yes	
2	Are you currently undergoing treatment for any respiratory illness?	No	Yes	Name of illness ()		Cough	No	Yes		
3	Have you experienced any chest problems in the past?	No	Yes	When? <input type="text"/> <input type="text"/> age <input type="checkbox"/> Pulmonary Tuberculosis <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pneumoconiosis <input type="checkbox"/> Pleuritis <input type="checkbox"/> Others ()		Phlegm	No	Yes		
4	Are any of your family members affected by cancer?	Lung	No	Yes	Relation ()	7	Do you smoke?	1 Not at all <input type="checkbox"/>	At what age did you start smoking? <input type="text"/> <input type="text"/> age	
		Others	No	Yes	Relation () Type of cancer ()			2 I quit <input type="checkbox"/>	At what age did you stop smoking? <input type="text"/> <input type="text"/> age	
5	Have you ever worked under the conditions listed in the following?	No • unsure	Yes	Manufacturing/processing using asbestos Ceramics Metalworking Other ()	9	Are you pregnant? (Females only)	No	Yes		
				Period <input type="text"/>			10	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		
					8	If you smoke, do you want to:	quit immediately <input type="checkbox"/>	quit someday <input type="checkbox"/>	don't want to quit <input type="checkbox"/>	
									How many cigarettes do you smoke in a day? (Please fill in even if you have stopped smoking.) <input type="text"/> <input type="text"/> cigarettes	
									How long have you smoked/have been smoking? <input type="text"/> <input type="text"/> year	

Stomach x-ray pre-examination questionnaire

※If you wish to have a gastroscopy screening instead, please complete the gastroscopy pre-examination questionnaire available at a medical institution.

2021 Toyohashi-shi

Stomach Cancer Questionnaire 令和3年度(2021年)胃がん検診票 please fast on the day of your examination

Page7

1	Have you received a stomach cancer examination in the past?	No	Yes	Year taken: <input type="text"/> Year Exam method: Abdominal X-ray • Gastroendoscopy Results of previous exam: Normal • Abnormal/No follow-up exam • Follow up exam needed (examination required abnormal findings Y/N)	7	Did you feel unwell after receiving the injection for the stomach and intestines examination?	No	Yes	Brief Description of Symptoms []	
2	Were you/ Are you currently affected by the following illnesses?	No	Yes	Stomach Cancer Stomach Ulcer Duodenal Ulcers Stomach Polyp Stomach Spasms Chronic Gastritis Gall Stones Others () Heart Disease Prostatic Hypertrophy Glaucoma Thyroid Gland Disease	8	Symptoms	No	Yes	Pain in Stomach (on an empty stomach • after eating • regardless) Abdominal Pain Nausea Heartburn Sensation that food is stuck in your (throat • chest • pit of your stomach) Bloating Heavy stomach Burp Lack of appetite Acid Reflux Diarrhoea Constipation Black stools Loss of weight Others ()	
3	Have you ever had abdominal surgery?	No	Yes	Name of illness and when? () <input type="text"/> years old			9	Do you take your meals at regular times?	Yes	No
4	Are any of your family members affected by cancer?	Stomach	No	Yes	Relation ()	10	Do you consume	Tobacco?	Don't smoke Quit smoking Smoke	I smoke (smoked) _____ cigarettes every day. I have been smoking (smoked) for _____ years. ※Please fill out the above even if you already quit smoking.
		Others	No	Yes	Relation () Type of cancer ()			Alcohol?	Don't drink Quit drinking Drink	Everyday • Sometimes • Rarely
5	Have you undergone helicobacter pylori tests?	No • Unsure	Yes	Results (Positive • Negative • Unsure)				Coffee?	Don't drink Drink	Everyday • Sometimes • Rarely
6	Have you undergone treatment for helicobacter pylori infection?	No • Unsure	Yes	Recovered fully from infection (When?) Did not recover fully from infection Unsure	12	Are you pregnant? (Females only)	No	Yes		

Address	〒		
Name	フリガナ ()		
Date of birth	years old		
No.	Type	24	
Tel.			
Fee		Sex	
Where did you receive the sample container from?	Medical institutions, or Lung/Stomach Cancer Mass Screenings		

Colon Cancer Screening Test Results	
Your result is marked by a O	
The result of your occult blood stool exam is as follows.	
<input type="checkbox"/>	Normal (Fecal Occult Blood Test Negative) No abnormalities were detected in this screening test. Most cancers in the early stages do not have any noticeable symptoms. We recommend that you take the cancer exam at least once a year even if you do not have any symptoms.
<input type="checkbox"/>	Further examination needed (Fecal Occult Blood Test Positive) Some abnormalities were detected in this screening test. Please bring this test result slip, the enclosed treatment form and envelope and your health insurance card and go for a detailed examination at a medical institution. You will be charged for the examination fees. We may contact you if we do not receive your medical results after 3 months. Thank you for your understanding.

※For the examination center use only

検査年月日	平成 年 月 日
-------	----------

<For enquiries>
 Toyohashi City Public Health Center Kenkou Zoushin-Ka TEL 39-9136 FAX 38-0770
 <Approved Screening Centers>
 Toyohashi Medical Association, Clinical Center TEL 45-2714

1	Have you received a colon cancer examination in the past?	No	Yes	Date of previous examination (YY)	7	What type of food do you like?	Meat • Fish • Vegetables •Others ()	
	2	Did you receive the stomach cancer test together with colon cancer test?	No	Yes		Results Normal examination required examination results abnormal findings Y/N	8	Are you taking any medication?
3	Are any of your family members affected by cancer?	Colon	No Yes	Relation ()	9	About taste food		
		Others	No Yes	Relation () Type of cancer ()		Do you smoke?	No Yes	
	4	Condition of your stomach and intestines	1. Very good 2. Good 3. Bad sometimes 4. Bad all the time			10	Do you drink alcohol?	No Yes
5	Do you suffer from hemorrhoids?	No	Yes			Do you drink coffee?	No Yes	
6	Are you currently affected by the following symptoms?	No	Yes	Bloody stools Diarrhoea Constipation		10 Other comments		

Please submit the stool sample container and the form together in the envelope.

1	Have you received examination for cancer in the uterus in the past?	No	Yes	This is my <input type="text"/> time Date of previous examination <input type="text"/> (YY) (MM) (DD) Results: Normal Further examination required (examination results abnormal findings Y/N)	7	Pregnancy/ Childbirth Pregnancy <input type="text"/> times Age at last child's birth <input type="text"/> years old Childbirth <input type="text"/> times Natural childbirth <input type="checkbox"/> Caesarean section <input type="checkbox"/>
2	Have you been affected by any uterine disorders?	No	Yes	Currently under treatment <input type="text"/> (YY) <input type="text"/> (MM) Date of the end of treatment <input type="text"/> (YY) (MM) (DD) Name of disorder ()	8	Have you received the HPV vaccine (cervical cancer vaccine)? No Yes First shot <input type="text"/> (YY) Number of shots received <input type="text"/> times
3	Do you have any blood relatives that had cancer? Uterine Other	No	Yes	Who () type of cancer (cervical cancer/endometrial cancer) Who () type of cancer ()	9	Symptoms Pain Bleeding/ Discharge in last 6 months
4	Are you currently taking the following?	No	Yes	IUD • Birth Control Pill • Other hormonal contraceptives		No Yes Menstrual cramps • Abdominal pain • Back pain • Others Colour (Fresh blood • Light spotting • Brown spotting • Others) Flow (Heavy • Slightly heavy • Light) When? Since <input type="text"/> months ago (Once • Sometimes • Always) Does it occur after the following? (After intercourse • After bowel movements • During urination • Irregularly • Others)
5	Menstrual Cycle	Age of first period <input type="text"/> years old Age of menopause <input type="text"/> years old Date of last period <input type="text"/> (MM) <input type="text"/> (DD) to <input type="text"/> (DD) (DD) Regular • Irregular Flow (Heavy • Medium • Light)				
6	Are you currently pregnant?	No	Yes	How far along? <input type="text"/> months		(For screening tests conducted at a medical institution) With the doctor's explanation, I understand the necessity and method of the examination and I agree to receive the examination for cancer in the uterus. (I agree • I do not agree)

Date (YYYY/MM/DD)

Signature

1	Have you undergone any breast cancer screening tests?	No	Yes	This is my <input type="text"/> time Date of previous test <input type="text"/> (YY) (MM) (DD) Type of test undergone Ultrasound • Mammography Where did the screening test take place? () Results Normal • Further examination required (examination results abnormal findings Y/N (Right • Left))	10	Menstrual Cycle Age of first period <input type="text"/> years old Age of menopause <input type="text"/> years old Date of last period <input type="text"/> (MM) <input type="text"/> (DD) - <input type="text"/> (DD) (DD) Regular • Irregular
2	Do you carry out breast self-exams?	No	Yes	Monthly • Sometimes	11	Pregnancy/Childbirth Pregnancy <input type="text"/> times I am currently pregnant at <input type="text"/> months After birth <input type="text"/> months Childbirth <input type="text"/> times Age at first child's birth <input type="text"/> years old Miscarriage <input type="text"/> times Age at last child's birth <input type="text"/> years old
3	Were you affected by any breast disorders or had surgery on your breasts?	No	Yes	Disorder • Surgery when I was <input type="text"/> years old Name of disorder (Right breast • Left breast)	12	Were you/ Are you currently nursing your child? ※You may not be permitted a mammograph if it has not been at least 6 month since you stopped breast feeding. No Yes <input type="checkbox"/> Currently nursing (Breast milk • Mixed) <input type="checkbox"/> Have nursed in the past (Breast milk • Mixed) Have you nursed in the past 6 months? (No • Yes)
4	Have you had a gynecological disorder or surgery? (Uterus • Ovary)	No	Yes	Disorder • Surgery when I was <input type="text"/> years old Name of disorder ()	13	subjective symptoms Pain No Yes Right Left From when? () Lumps No Yes Right Left From when? () Nipple changes No Yes Right Left From when? () Abnormal discharges No Yes Right Left From when? ()
5	Have you undergone hormone therapy? (Menopause)	No	Yes	Treatment duration <input type="text"/> months Name of disorder ()	14	Are any of your family members affected by cancer? Breast No Yes Relation () Others No Yes Relation () Type of cancer ()
6	Have you undergone hormone therapy? (Menstrual irregularity)	No	Yes	Treatment duration <input type="text"/> months Name of disorder ()	15	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
7	Have you undergone radiation therapy?	No	Yes	Treatment duration <input type="text"/> months Name of disorder ()		
8	Have you undergone for any of the following?	No	Yes	<input type="checkbox"/> Pacemaker implantation <input type="checkbox"/> V-P(Ventriculoperitoneal shunting) <input type="checkbox"/> Chest Port insertion <input type="checkbox"/> Breast implants		
9	Were you/ Are you currently affected by cancer or any other illnesses?	No	Yes	<input type="text"/> years old Name of illness ()		

2021 Toyohashi osteoporosis pre-examination questionnaire 令和3年度(2021年)骨粗しょう症検診

[2021 Osteoporosis Examination Schedule: Reservation required]

Health center hours : 9 : 00~12 : 00 Hours for other locations : 9 : 30~11 : 30 Hours for Re-spa : 10 : 00~12 : 00

Date	Location	Additional available exams		Date	Location	Additional available exams	
		Breast Cancer	Cervical Cancer			Breast Cancer	Cervical Cancer
2021/6/8	Re-spa Toyohashi	-	-	2021/12/6	Civic Cultural Center	-	-
2021/6/30	Shimaki Community Center	-	-	2021/12/17	Health Center	○	○
2021/7/12	Civic Cultural Center	-	-	2021/12/20	Health Center	○	○
2021/8/6	Health Center	○	○	2021/12/21	Health Center	○	○
2021/8/27	Health Center	○	○	2021/12/24	Health Center	○	○
2021/9/3	Health Center	○	○	2021/1/11	Health Center	○	○
2021/9/13	Civic Cultural Center	-	-	2021/1/12	Health Center	○	○
2021/10/25	Health Center	○	○	2021/1/13	Health Center	○	○
2021/11/8	Civic Cultural Center	-	-	2021/1/14	Health Center	○	○
2021/11/22	Civic Cultural Center	-	-	2021/1/18	Health Center	○	○
2021/11/26	Shimaki Community Center	-	-	2021/1/20	Health Center	○	○
2021/12/1	Health Center	○	○	2021/1/21	Health Center	○	○



1	Have you ever received a any osteoporosis medical exam before?	No	Yes	When? Results: <input type="text"/> (Year) No abnormalities found • Medical advice required • Full medical exam required • Unknown	8	Do you Smoke	No	Yes	
2	Do you have any pain in your hips and back?	No	Yes	To what degree? 1. It's noticeable 2. Bearable, but bothersome 3. Need painkillers to cope	8	Drink alcohol	No	Yes	
3	Do you think your height has shrunk?	No	Yes		9	Drink coffee	No	Yes	
4	Do you think your hips and back are beginning to bend?	No	Yes		9	Do you consume instant foods, snacks, soft drinks etc often?	No	Yes	
5	Have you ever been diagnosed with the following?	No	Yes	Kidney disease Liver disease Hyperlipidemia Osteoporosis Thyroid disease Arthrosis Diabetes Other ()	10	Do you consume soy/dairy products every day?	Yes	No	
6	Have you ever fractured a bone?	No	Yes	Where () <input type="text"/> Age of the fracture occurred	11	Do you exercise 3-4 times a week?	Yes	No	
7	Have you ever undergone an extreme diet?	No	Yes	<input type="text"/> Age during diet <input type="text"/> length of diet period bodyweight before diet <input type="text"/> kg Bodyweight after diet <input type="text"/> kg	12	Have you had menopause?	Yes	No	Age you had menopause ()
					13	Height <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> cm	Bodyweight <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg		

2021 Toyohashi-shi Prostate Cancer Questionnaire

令和3年度(2021年)前立腺がん検診票

1	Have you received a Prostate cancer examination in the past?	No	Yes	Date of previous examination <input type="text"/> (Year) Previous numerical value <input type="text"/>
2	Were you affected by the following?	No	Yes	Prostate gland enlargement • Inflammation of the prostate
3	Are you currently undergoing treatment for the following?	No	Yes	Prostate gland enlargement • Inflammation of the prostate
4	Do you have any blood relatives that had cancer?	No	Yes	Grandfather/father/brothers
	Prostate cancer	No	Yes	Grandmother/mother/sisters
	Breast	No	Yes	Grandmother/mother/sisters
5	Are you currently suffering from any of the following?	No	Yes	Frequent urination Increased urination at night Slow flow of urine Increased urinary urgency Discomfort while urinating
	Prostate cancer	No	Yes	

