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

2022 Toyohashi-city Respiratory (Tuberculosis/Lung Cancer) Questionnaire 令和4年度（2022年）肺（結核・肺がん）検診票

1	Have you received the lung examination in the past?	No	Yes	Year taken: Year Place received ( ) Results of previous exam: Normal • Abnormal/No follow-up exam • Follow-up exam needed (examination required abnormal findings Y/N)	
2	Are you currently undergoing treatment for any respiratory illness?	No	Yes	Name of illness ( )	
3	Have you experienced any chest problems in the past?	No	Yes	When? age Pulmonary Tuberculosis Lung Cancer Pneumonia Pneumoconiosis Pleuritis Others ( )	
4	Are any of your family members affected by cancer? Lung	No	Yes	Relation ( )	
	Others	No	Yes	Relation ( ) Type of cancer ( )	
5	Have you ever worked under the conditions listed in the following?	No・unsure	Yes	Manufacturing/processing using asbestos Ceramics Metalworking Other ( ) Period	

6	Symptoms Cough	No	Yes	
	Phlegm	No	Yes	
	Coughing up blood in the past 6 months	No	Yes	
7	Do you smoke?	1 Not at all / 2 I quit / 3 Yes		At what age did you start smoking? age At what age did you stop smoking? age How many cigarettes do you smoke in a day? (Please fill in even if you have stopped smoking.) cigarettes How long have you smoked/have been smoking? year
8	If you smoke, do you want to:	quit immediately	quit someday	don't want to quit
9	Are you pregnant? (Females only)	No	Yes	
10	Height ・ cm Weight ・ kg			

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.

2022 Toyohashi-shi Stomach Cancer Questionnaire 令和4年度（2022年）胃がん検診票 □please fast on the day of your examination

1	Have you received a stomach cancer examination in the past?	No	Yes	Year taken 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)	
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	
3	Have you ever had abdominal surgery?	No	Yes	Name of illness and when? ( ) years old	
4	Are any of your family members affected by cancer? Stomach	No	Yes	Relation ( )	
	Others	No	Yes	Relation ( ) Type of cancer ( )	
5	Have you undergone helicobacter pylori tests?	No・Unsure	Yes	Results (Positive • Negative • Unsure)	
6	Have you undergone treatment for helicobacter pylori infection?	No・Unsure	Yes	Recovered fully from infection (When?) Did not recover fully from infection Unsure	

7	Did you feel unwell after receiving the injection for the stomach and intestines xamination?	No	Yes	Brief Description of Symptoms [ ]
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) Bloatedness Heavy stomach Burp Lack of appetite Acid Reflux Diarrhoea Constipation Black stools Loss of weight Others ( )
9	Do you take your meals at regular times?	Yes		No
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.
	Alcohol?	Don't drink / Quit drinking / Drink		Everyday • Sometimes • Rarely
	Coffee?	Don't drink / Drink		Everyday • Sometimes • Rarely
12	Are you pregnant? (Females only)			No • Yes

2022 Toyohashi-city Colon Cancer Questionnaire 令和4年度（2022年）大腸がん検診票

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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		

※For the examination center use only

検査年月日	令和	年	月	日

Colon Cancer Screening Test Results

Your result is marked by a O

The result of your occult blood stool exam is as follows.

☐ **Normal（Fecal Occult Blood Test Negative）**
No abnormalities were detected in this screening test.
Most cancers in the early stages do not have any noticable symptoms. We recommend that you take the cancer exam at least once a year even if you do not have any symptoms.

☐ **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 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

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1	Have you received a colon cancer examination in the past?		No	Yes	Date of previous examination ☐ (YY) Results Normal examination required examination results abnormal findings Y/N
2	Did you receive the stomach cancer test together with colon cancer test?		No	Yes	
3	Are any of your family members affected by cancer?	Colon	No	Yes	Relation（ ）
		Others	No	Yes	Relation（ ） Type of cancer（ ）
4	Condition of your stomach and intestines		1. Very good 2. Good 3. Bad sometimes 4. Bad all the time		
5	Do you suffer from hemorrhoids?		No	Yes	
6	Are you currently affected by the following symptoms?		No	Yes	Bloody stools Diarrhoea Constipation

7	What type of food do you like?	Meat ・ Fish ・ Vegetables ・Others（ ）		
8	Are you taking any medication?	No	Yes	Name of medication（ ）
9	About taste foo			
	Do you smoke?	No	Yes	
	Do you drink alcohol?	No	Yes	
	Do you drink coffee?	No	Yes	
10	Other comments			

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

2022 Toyohashi-city Cervical Cancer Questionnaire 令和4年度（2022年）子宮頸がん検診票

1	Have you received examination for cancer in the uterus in the past?	No	Yes	This is my ☐ time Date of previous examination ☐ (YY) Results： Normal Further examination required (examination results abnormal findings Y/N)
2	Have you been affected by any uterine disorders?	No	Yes	Currently under treatment ☐ (YY) ☐ (MM) Date of the end of treatment Name of disorder （ ）
3	Do you have any blood relatives that had cancer? Uterine cancer	No	Yes	Who （ ） type of cancer （ cervical cancer/endometrial cancer ）
	Other	No	Yes	Who （ ） type of cancer （ ）
4	Are you currently taking the following?	No	Yes	IUD・Birth Control Pill ・Other hormonal contraceptives
5	Menstrual Cycle			Age of first period ☐ years old Age of menopause ☐ years old Date of last period ☐ (MM) ☐ (DD) to ☐ (DD) Regular ・ irregular Flow（Heavy・Medium・Light）
6	Are you currently pregnant?	No	Yes	How far along? ☐ months

7	Pregnancy/ Childbirth			Pregnancy ☐ times Age at last child's birth ☐ years old Childbirth ☐ times Natural childbirth ☐ times Caesarean section ☐ times
8	Have you received the HPV vaccine (cervical cancer vaccine)?	No	Yes	First shot ☐ (YY) Number of shots received ☐ times
9	Symptoms Pain	No	Yes	Menstrual cramps・Abdominal pain・Back pain・Others
	Bleeding/ Discharge in last 6 months	No	Yes	Colour (Fresh blood・Light spotting・Brown spotting・Others) Flow (Heavy ・ Slightly heavy ・ Light) When? Since ☐ months ago (Once ・ Sometimes ・ Always) Does it occur after the following? (After intercourse ・ After bowel movements ・ During urination ・ Irregularly・Others)

If you have subjective symptoms such as bleeding other than menstruation or bleeding after menopause,do not wait for a checkup to see a medical institution.

2022 Toyohashi-city Breast Cancer Questionnaire 令和4年度（2022年）乳がん検診票

1	Have you undergone any breast cancer screening tests?	No	Yes	This is my ☐ time Date of previous test ☐ (YY) 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))
2	Do you carry out breast self-exams?	No	Yes	Monthly ・ Sometimes
3	Were you affected by any breast disorders or had surgery on your breasts?	No	Yes	Disorder ・ Surgery when I was ☐ years old Name of disorder （ Right breast ・ Left breast ）
4	Have you had a gynecological disorder or surgery? （Uterus・Ovary）	No	Yes	Disorder ・ Surgery when I was ☐ years old Name of disorder （ ）
5	Have you undergone hormone therapy? (Menopause)	No	Yes	Treatment duration ☐ months Name of disorder （ ）
6	Have you undergone hormone therapy? (Menstrual irregularity)	No	Yes	Treatment duration ☐ months Name of disorder （ ）
7	Have you undergone radiation therapy?	No	Yes	Treatment duration ☐ months Name of disorder （ ）
8	Have you undergone for any of the following?	No	Yes	☐ Pacemaker implantation ☐ V-P(Ventriculoperitoneal shunting) ☐ Chest Port insertion ☐ Breast implants
9	Were you/Are you currently affected by cancer or any other illnesses?	No	Yes	☐ years old Name of illness （ ）

10	Menstrual Cycle			Age of first period ☐ years old Age of menopause ☐ years old Date of last period ☐ (MM) ☐ (DD) - ☐ (DD) Regular ・ Irregular
11	Pregnancy/Childbirth			Pregnancy ☐ times Currently Pregnant ☐ months After birth ☐ months Possibility of pregnancy (No・Yes) Childbirth ☐ times Age at first child's birth ☐ years old Miscarriage ☐ times Age at last child's birth ☐ years old
12	Were you/Are you currently nursing your child? **※You may not be permitted a mamograph if it has not been at least 6 month since you stopped breast feeding.**	No	Yes	☐ Currently nursing （Breast milk・Mixed） ☐ Have nursed in the past（Breast milk・Mixed） Have you nursed in the past 6 months? （ No・ Yes ）
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? （ ）
14	Are any of your family members affected by cancer? Breast	No	Yes	Relation （ ）
	Others	No	Yes	Relation （ ） Type of cancer （ ）
15	New corona vaccination history	No	Yes	Final Seeding Day （ ）
16	Height ☐☐☐.☐cm Weight ☐☐☐.☐kg			

1	Have you received a Prostate cancer examination in the past?		No	Yes	Date of previous examination ☐ (Y) Previous numerical value ☐
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?	Prostate cancer	No	Yes	Grandfather/father/brothers
		Breast	No	Yes	Grandmother/mother/sisters
		Ovarian cancer	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