

< 検診票翻訳文 >

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

1	Are you currently undergoing treatment for any of the following?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	3	Symptoms	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<input type="checkbox"/> My vision in one eye is blurry and cannot see things clearly like before, even with glasses.
				<input type="checkbox"/> Liver disease	<input type="checkbox"/> Heart disease					<input type="checkbox"/> I am very sensitive to light and I see a rainbow-like reflection around the light.
2	Have you suffered from any eye diseases?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	<input type="checkbox"/> Hyperlinemia	<input type="checkbox"/> Kidney disease					<input type="checkbox"/> My vision is getting narrow and I stumble easily.
				<input type="checkbox"/> Allergies	<input type="checkbox"/> Collagen disease					<input type="checkbox"/> I see black spots floating in my vision.
				<input type="checkbox"/> Tuberculosis						<input type="checkbox"/> I have distorted vision and can see a dark gray spot in the center of my vision.
				<input type="checkbox"/> Others ()						<input type="checkbox"/> I have diabetes but I have not seen an eye doctor for more than one year.
				<input type="checkbox"/> Cataracts						
				<input type="checkbox"/> Glaucoma						
				<input type="checkbox"/> Age-related macular degeneration						
				<input type="checkbox"/> Others ()						