Page 1

個人情報の取得について同意されますか？(Do you agree with our policy for collecting personal information?)

Yes

Page 2

◆主な仕事について（Occupation）

主な仕事について、該当するもの１つを選択してください。(Please click one item below.)

1. Technologist / 2. Manager / 3. Office worker

4. Sales position / 5. Sales worker / 6. Farmer・Fisher

7. Miner / 8. Industry worker / 9. Civil engineering

10. Transportation・Communication / 11. Security position / 12. Service industry

13. Other

◆主な業務歴について(Work history)

これまでに、重量物の取扱いのある業務経験がありますか。(Have you ever handled heavy objects in your work?)

Yes / No

これまでに、粉塵の取扱いのある業務経験がありますか。(Have you ever worked in an environment with lots of rocks, sand, dust?)

Yes / No

これまでに、激しい振動を伴う業務経験がありますか。(Have you ever used a machine that vibrates at high speed in your work?)

Yes / No

これまでに、有害物質の取扱いのある業務経験がありますか。(Have you ever handled a hazardous substance in your work?)

Yes / No

これまでに、放射線の取扱いのある業務経験がありますか。(Have you ever handled radiation in your work?)

Yes / No

現在の職場では、どのような勤務体制で働いていますか。(What is your current work shift?)

Always on a day shift / Always on a night shift / On an alternative shift (Both day and night shift)

現在の職場での、直近１ヶ月間の１日あたりの平均的な労働時間はどのくらいですか(What are your average hours worked per day at your current workplace during the past month? Excluding lunchtime and break time and including overtime)

Less than 6 hours / 6 or more hours and less than 8 hours / 8 or more hours and less than 10 hours / 10 or more hours

現在の職場での、直近１ヶ月間の１週間あたりの平均的な労働日数はどのくらいですか。(What are your average days worked per week at your current workplace during the past month?)

Less than 3 days / 3 or more days and less than 5 days / 5 days / 6 or more days

Page 3

◆自覚症状について(Subjective symptoms)

最近 1 年以内の自覚症状について、該当するものを選択してください。(Please click an applicable thing about subjective symptoms within one year.)

1. Have a headache / 2. Dysphagia / 3. Sudden weight loss（more than3~4kg/month）

4. Pain in a chest, the chest a tightened/5. Discomfort (or Pain) of the pit of the stomach /6. Sleepless, Depression, Strong feeling of anxiety

7. Cough, Sputum / 8. Diarrhea, Constipation / 9. Thirsty, Over volume of urinary output

10. Bloody sputum / 11. Hematochezia / 12. A pulse is fast (or irregular)

13. Other symptom which influence on daily life

上記以外に日常生活に影響を及ぼす症状があればお答えください。

※その他を選択された方のみ(If you click “13”, please type other symptom which influence on daily life.)

◆既往歴・現病歴について

該当する疾患で、治療中・通院中の場合は「治療中」、過去の病気の場合は「既往」いずれか一つを選択してください。(When you continue to be under management for each disease, please select “治療中”. When you had any diseases in the past, please select “既往”.)

特になし(None)

1. Hypertension

2. Diabetes mellitus

3. Dyslipidemia

4. Hyperuricemia(gout)

11. Stroke

12. Myocardial infarction

13. Angina
14. Arrhythmia
15. Heart valve disease
16. Cardiomyopathy
17. Aortic aneurysm
19. Other heart disease
21. Glaucoma
31. Hearing impairment (Difficulty in hearing)
41. Lung cancer
42. Pulmonary tuberculosis
43. Pneumonia
44. Asthma
45. Sleep apnea syndrome
51. Reflux esophagitis
52. Esophageal cancer
53. Stomach cancer
54. Gastric ulcer
55. Stomach polyp
56. Duodenal ulcer
57. Colon cancer
58. Colon polyp
59. Ulcerative colitis
60. Crohn's disease
71. Liver cancer
72. Cirrhosis
73. Fatty liver
74. Chronic hepatitis B
75. Chronic hepatitis C
81. Gall stone
82. Gallbladder polyp
91. Pancreas cancer
101. Renal cancer
102. Nephritis
103. Urinary stone
104. Chronic renal failure
111. Thyroid disease
112. Articular rheumatism
121. Anemia

122. Malignant lymphoma
123. Leukemia
131. Prostate cancer
132. Prostate hypertrophy
141. Breast cancer
151. Uterine myoma
152. Cervical cancer
153. Uterine cancer
154. Ovarian cyst
999. Other large disease which is needed hospitalization or surgery

上記以外の疾患で既往歴があれば疾患名をお答えください。(If you select “999=既往”, please type other large disease which is needed hospitalization or surgery.)

上記以外の疾患で治療中があれば疾患名をお答え下さい。(If you select “999=治療中”, please type other large disease which is needed hospitalization or surgery.)

1:血圧を下げる薬を使用していますか。(Do you have any medicine for hypertension?)
Yes/No

2:インスリン注射または血糖を下げる薬を使用していますか。(Do you have any medicine for diabetes, including insulin injection?)
Yes/No

3:コレステロールや中性脂肪を下げる薬を使用していますか。(Do you have any medicine for hyperlipidemia, especially high level of serum LDL-cholesterol ?)
Yes/No

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◆各質問にあてはまるものに選択してください。

医師から、脳卒中（脳出血、脳梗塞等）にかかっているといわれたり、治療を受けたことがありますか。(Have you ever been told by the doctor you have had a stroke (cerebral hemorrhage, brain infraction, etc.) and received treatment?)
Yes/No

医師から、心臓病（狭心症、心筋梗塞等）にかかっているといわれたり、治療を受けたことがありますか。(Have you ever been told by the doctor you have had a heart disease (angina pectoris, myocardial infarction, etc.) and received treatment?)
Yes/No

医師から、慢性腎臓病や腎不全にかかっているといわれたり、治療（人工透析など）を受けていますか。(Have you ever been diagnosed as having chronic kidney disease or kidney failure and received treatment (dialysis therapy)?
Yes/No

医師から、貧血といわれたことがありますか。(Have you ever been diagnosed as anemic?)
Yes/No

現在、たばこを習慣的に吸っていますか。(Do you smoke habitually?)
※「現在、習慣的に喫煙している者」とは、「合計 100 本以上、又は 6 ヵ月以上吸っている者であり、最近 1 ヵ月も吸っている者 ("Habitually" refers to more than 100 pieces since one started smoking, or smoking more than 6 months, and continuing during the recent one months as well.)
I have never smoked. /I've been off cigarettes more than one month. /I'm a smoker.

20 歳の時から体重が 10kg 以上増加していますか。(Have you gained more than 10kg compared to when you were at the age of 20?)
Yes/No

1 回 30 分以上の軽く汗をかく運動を週 2 日以上、1 年以上実施していますか。(Do you exercise which the body sweats lightly for more than 30 minutes per day twice a week, more than a year?)
Yes/No

日常生活において歩行または同等の身体活動を 1 日 1 時間以上実施していますか。(Do you perform walking exercise or physical activity equivalent to it more than one hour a day?)
Yes/No

ほぼ同じ年齢の同性と比較して歩く速度が速いですか。(Do you walk faster than people with the same sex in your generation?)
Yes/No

食事をかんで食べるときの状態はどれにあてはまりますか。(What is the following condition when eating?)
I can bite anything. /Sometimes I can hardly bite, as I am concerned about teeth, gums, and bite. /I can hardly bite.

人と比較して食べる速度が速いですか。(Do you eat faster than people around you?)
Faster/Normal/Slower

就寝前の 2 時間以内に夕食をとることが週に 3 回以上ある。(Do you have an evening meal within 2 hours before going to bed more than three times a week?)
Yes/No

朝昼夕の 3 食以外に間食や甘い飲み物を摂取していますか。(Do you take snacks and drinks other than three meals?)
Every day/Occasionally /I hardly take it.

朝食を抜くことが週に 3 回以上ありますか。(Do you skip breakfast more than three times a week?)
Yes/No

お酒（清酒、焼酎、ビール、洋酒など）を飲む頻度はどれくらいですか。(How much is the frequency to drink alcohol?)
Every day/Occasionally (2-6days a week)/None or rarely

飲酒日の 1 日当たりの飲酒量はどれくらいですか。(How much do you drink alcohol per day?)
日本酒 1 合（180ml）の目安
ビール中瓶 1 本（約 500ml)、焼酎 25 度（110ml)、ウイスキーダブル 1 杯（60ml)、ワイン 2 杯（240ml）(1 unit =180ml of sake, 500ml of beer, 110ml of 25 degrees shochu, 60ml of whiskey, 240ml of wine)
Less than 1 unit/1 to less than 2 units/2 to less than 3 units/More than 3 units

睡眠で休養が十分とれていますか。(Do you get enough sleep to recover from activities?)
Yes/No

運動や食生活等の生活習慣を改善してみようと思いますか。(Would you like to make life style change including food habits and physical exercises?)

No / I am going to change it roughly within 6 months. /I am going to change it roughly within a month, or I have started little by little.

I started only within 6 months ago. /I already started more than 6 months ago.

生活習慣の改善について保健指導を受ける機会があれば、利用しますか。(If you have an opportunity to participate in any educational programs for improving your lifestyle, would you like to make use of it?)

Yes/No

何か健康について相談したい事がありますか。(Do you have any health issue on which you need consultation?)

Yes/No

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◆喫煙について（smoking)

「吸っていたが禁煙した」「現在吸っている」にチェックを入れた方のみ 1 日のタバコの本数についてお答えください。(If you click “I’m off cigarettes.” or “I’m a smoker.”, how many cigarettes do you smoke per day?)

「吸っていたが禁煙した」「現在吸っている」にチェックを入れた方のみ喫煙期間についてお答えください。(If you click “I’m off cigarettes.” or “I’m a smoker.”, how many years have you smoked?)

◆ピロリ菌の検査について(Helicobacter pylori)

①ピロリ菌の検査をしたことがありますか。(Have you had an exam for Helicobacter pylori?)

Yes（to Q②) / No

②ピロリ検査の結果はいかがでしたか。(How was the result?)

Positive（to Q③) / Negative / I forgot.

③除菌治療を受けられましたか。(Have you been treated for removing Helicobacter pylori?)

Yes（to Q④) / No / I forgot.

④除菌の結果はいかがでしたか。(How was the result?)

Success / Failure / I don’t know.

胃レントゲンについて（Barium swallowing test）

以下の症状・病歴等に該当しますか。(Please click symptom or diseases below in the past)

I do not meet any items.

I have had allergy when I took barium. /I have constipation, or today is more than third day after I had last defecation. /I am undergoing artificial dialysis, I constructed an artificial anus.

I have had ileus in the past. /I have had gastric or duodenal ulcer operation in your abdomen. / I have management for ulcerative colitis or Crohn's disease.

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Web での結果配信サービスをご希望されますか。(Would you like to receive your result on website? The language is only Japanese.)

Yes/No

メールアドレスをご入力ください。(Please type your own e-mail address if you'd like to receive your result on website.)