

Pre-Health Check-up Questionnaire (2023)

※No medical check-up available, if you are coronavirus-infected (or a close contact person), or find yourself physical deconditioning. Please contact the University Health Support Center (097-554-7477).

※Please complete the area inside the bold lines with a black ballpoint pen beforehand.

Health Examination Date 2023 / /

| | | |
|-----------------------------------|---|--------|
| Student ID Number | Name | |
| Country of birth | Date of Birth (YYYY/MM/DD) / / () | M F |
| Currently Under medical treatment | ① Are you currently under medical treatment of any major disease? Or have you ever had any major disease? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please write down a disease name and the approximate age you had that disease. () Disease name () | |
| Past Medical history | ② Do you wish to see a doctor or have a medical consultation at the Health Support Center? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe your proposed consultation briefly. () | |
| COVID-19 | Have you received a COVID-19 vaccine, and how many times? If yes, please fill in the number of vaccinations received. <input type="checkbox"/> No <input type="checkbox"/> Yes () Have you been ever infected with COVID-19 and how many times? If yes, please fill in number of times COVID-19 infected. <input type="checkbox"/> No <input type="checkbox"/> Yes () | |
| Tuberculosis (TB) | Have you ever had tuberculosis (e.g. pulmonary TB, TB pleurisy, or pleuritis) ? <input type="checkbox"/> No <input type="checkbox"/> Yes Have you ever taken preventive medicine against TB? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Life Style | 1. Smoking Habits <input type="checkbox"/> No <input type="checkbox"/> Yes Smoking History (for year(s)) Smoking amount (/day) Type <input type="checkbox"/> Cigarettes <input type="checkbox"/> E-cigs or heat-not-burn tobacco <input type="checkbox"/> Both <input type="checkbox"/> Quit () year(s) ago / Smoking Habits for () year(s) Smoking amount (/day) 2. Drinking Habits <input type="checkbox"/> No <input type="checkbox"/> Yes (<input type="checkbox"/> Everyday <input type="checkbox"/> Sometimes) 3. Physical Activity Habits <input type="checkbox"/> No <input type="checkbox"/> Yes (<input type="checkbox"/> Everyday <input type="checkbox"/> Sometimes) | |
| For woman | Is there any possibility you might be pregnant? If yes, you cannot have an X-ray taken. Please notify staff. <input type="checkbox"/> No <input type="checkbox"/> Yes | |

以下は、健診時に記入します。 Please leave this area blank.

| | | | |
|-------|------|--|--------|
| 受付サイン | 身体計測 | 身長 c m | 体重 k g |
| | 血圧 | ① | ② |
| | 胸部X線 | N O. | |
| | 内科診察 | <input type="checkbox"/> 異常なし <input type="checkbox"/> 所見あり () <input type="checkbox"/> 診断書発行時に考慮 | 医師 |

※We will use the information from this pre-health check-up for the purpose of your health maintenance while you study at Oita University but will not use it for any other purposes. However, if we need to use the information in an emergency, like dealing with an infectious disease, or if we need it to protect your life, we may then exceptionally disclose the information to a third party without obtaining your consent.