

Please read carefully the following statements before undergoing the medical check-up.
 Refrain from attending if you are not feeling well on the day of your medical check-up.
 (Those with a body temperature of 37.5 degrees or higher and persistent cold symptoms).

0 2 1

- Please come to the appointment with clothes that are easy to put on and take off. Remove any tights, stockings, bodysuits, dresses etc., that do not open on the chest area, or, any items that compress the body or abdomen such as girdles and corsets, beforehand.
- Please note that during the medical check-up, your body may be directly touched.
- Please contact us in advance if for some reason, you are unable to attend the check-up by yourself or, are unable to remain calm.
- Please note that depending on the reasons listed below, we may ask you to refrain from undergoing a check-up on the reserved day.
- Please refrain from drinking alcohol or doing strenuous exercise from the day before your medical check-up.

Those undergoing regular health check-ups

Those undergoing a blood test

- If you are asked to refrain from eating breakfast, you can only drink beverages that do not contain sugar (such as water or tea). (Juices, milk, coffee with sugar or milk, etc., contain sugar and they are not allowed.) However, for those undergoing a stomach X-ray examination at the same time, including taking medications, you can only drink less than 200 ml of water or plain hot water up to 2 hours before the examination, and refrain from any other eating or drinking. In addition, if you need to take medications in the morning (for high blood pressure, diabetes, etc.), please be sure to consult with your primary care doctor before undergoing the examination.
- If you have any of the following, please be sure to notify us before a blood sample is taken from you.
 - Those who
 - have felt unwell due to a blood sample being taken in the past
 - have difficulty stopping bleeding
 - are hypersensitive to alcohol disinfectants
 - had to have a blood sample taken again due to "platelet aggregation" in the past.
- Taking of a blood sample may cause symptoms such as subcutaneous hematoma, pain and numbness. If these symptoms have interfered with your daily work in the past, and if you have ever had to visit a hospital due to any of these symptoms, we recommend that you have a health check-up at the hospital.
- Please be careful not to lift anything heavy for one hour after a blood sample has been taken.

Those undergoing the following tests

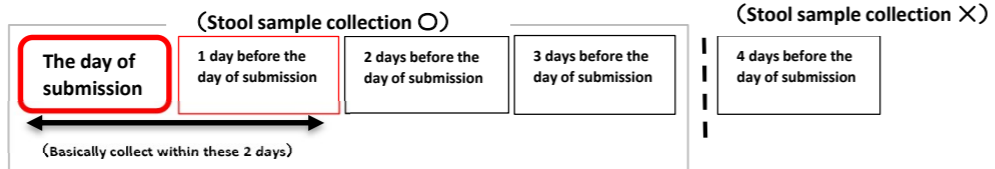
- If you are having a fundus/ intraocular pressure test and are wearing contact lenses, please come wearing glasses on the day of your check-up or, bring a glasses case to put them in as you remove them at the medical check-up.
- Please note that if you are on your menstrual period, you may not receive an accurate result from the urine test or urine sediment test.

Those undergoing chest X-ray examination

- Those who are pregnant or may be pregnant cannot undergo a chest X-ray examination.
- If you are undergoing treatment for lung cancer, etc., or if you are undergoing follow-up observation, please be sure to consult your family doctor before the check-up.
- If, for any reason, you are unable to maintain the body position as directed by the person in charge, you may be asked to refrain from the test. Additionally, even if the test is done, the results may be inconclusive. Therefore, if you have any concerns in advance, be sure to consult us before the day of your health check-up. We may also ask you to refrain from attending your appointment on the day of the medical examination if the radiology technician deems it difficult for you to attend the examination. We appreciate your understanding.
- Wear plain, thin clothing without buttons, plastic, metal, or vinyl logos. Please remove necklaces, bras, and bra tops, etc., poultices such as "Salonpas" and others, magnetic buttons, thermal bags (warmers), etc.
- Please contact us in advance if any of the following apply to you.
 - Those who, for some reason, have difficulty maintaining a given position (for about 1 minute) as instructed by the person in charge.
 - Those who have extremely curved hips (waist, lower back).
 - Those who have difficulty going up and down the stairs at the entrance to the examination car and require assistance or companionship.

Those undergoing a colorectal cancer (fecal occult blood) check-up

- People with gastrointestinal symptoms such as abdominal pain, diarrhea or bleeding from hemorrhoids cannot undergo a colorectal cancer (fecal occult blood) check-up. (Visit a hospital (clinic) doctor.)
- Those who are on their menstrual period cannot undergo the check-up.
- If you are currently undergoing treatment or follow-up at a medical institution for a colon or stomach disease, etc., please be sure to consult your family doctor before the check-up.
- The result will be based on two days' stools. Therefore, if only one day's is submitted, it will be difficult to obtain an accurate result. Please be sure to submit two days' stool.
- Accurate testing cannot be performed if you use a stool collection container which expiration date has passed, so please use the containers distributed this year that are within the expiration date. (The expiration date is clearly marked on the container.) Also, tests cannot be performed on containers used by other medical examination institutions. (Please collect your stool using the container provided by our center.) Thank you for your understanding.
- Please store the collected stool in a cool, dark place (out of sunlight, in a cool, well-ventilated place) until the submission date.
- Please note the following points regarding stool collection.
 - You need to collect 2 days stools, but be sure to collect them on different days.
 - Please do not forget to write your name and the date of intake on the defecation container and the submission bag.
 - There are two days to collect your stool: the day before the submission date and the day of submission. If you tend to be constipated, it may be difficult to collect stool samples, take 2 stool samples from 3 days before the submission date until the day of submission. (This is because the result may not be accurate if too many days have passed since stool samples collection.)
 - Please peel off the barcode label from the stool sample container and attach it to the designated barcode placement area on the examination form.



※ This form is for the exclusive use of our center. It cannot be repurposed.

Health check up examination form(2026 Fiscal Year)

<input type="radio"/> 未 胸部X線 略痰 <input type="checkbox"/> 肺 <input type="checkbox"/> 2R		受診日 受診番号 健診機関使用欄	
計測 身長 <input type="radio"/> 未 <input type="checkbox"/> 腰		事業所名等	
体重 <input type="radio"/> 未		氏名 カナ 漢字	
BMI <input type="checkbox"/>		生年月日 大・昭・平 年 月 日	
腹囲 <input type="radio"/> 未		年齢 歳 性別 男性・女性	
尿 蛋白 <input type="checkbox"/> - <input type="checkbox"/> ± <input type="checkbox"/> + <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ 糖 <input type="checkbox"/> - <input type="checkbox"/> ± <input type="checkbox"/> + <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ 潜血 <input type="checkbox"/> - <input type="checkbox"/> ± <input type="checkbox"/> + <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ ウロ <input type="checkbox"/> - <input type="checkbox"/> 正 <input type="checkbox"/> + <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ PH 5 6 7 8 9		番号 事業所等 個人等	
その他 尿沈渣 <input type="checkbox"/> 有 尿比重 <input type="checkbox"/> 有 <small>※未実施理由(1:生理中、2:腎疾患等による排尿障害、3:その他)</small>		コース	
血圧 最大 <input type="checkbox"/> 最小 <input type="checkbox"/> <input type="radio"/> 未		他覚所見 <input type="checkbox"/> 1.心雑音 (01) <input type="checkbox"/> 5.呼吸音異常 (10) <input type="checkbox"/> 2.不整脈 (02) <input type="checkbox"/> 6.その他 <input type="radio"/> <input type="checkbox"/> 3.貧血 (04) (色覚検査(健常・異常疑い) 言語障害・運動障害) <input type="checkbox"/> 4.甲状腺肥大 (14)	
食後経過時間 時間 分		判定 <input type="checkbox"/> 異常なし <input type="checkbox"/> 軽度異常 <input type="checkbox"/> 要精密検査・治療	
視力 右 <input type="checkbox"/> 裸眼 <input type="checkbox"/> 矯正 <input type="checkbox"/> 左 <input type="checkbox"/> 裸眼 <input type="checkbox"/> 矯正 <input type="checkbox"/>		医師サイン <input type="checkbox"/> 未 胃検診の可否 <input type="checkbox"/> 可 <input type="checkbox"/> 不可 コメント	
聴力 1000Hz 右 <input type="checkbox"/> 有 <input type="checkbox"/> 無 <input type="checkbox"/> 左 <input type="checkbox"/> 有 <input type="checkbox"/> 無 4000Hz 右 <input type="checkbox"/> 有 <input type="checkbox"/> 無 <input type="checkbox"/> 左 <input type="checkbox"/> 有 <input type="checkbox"/> 無 会話法 右 <input type="checkbox"/> 有 <input type="checkbox"/> 無 <input type="checkbox"/> 左 <input type="checkbox"/> 有 <input type="checkbox"/> 無 <input type="radio"/> 未検査		◆Women's specific health concerns (for female respondents) *Optional This questionnaire is intended to be useful for your own health management, and responding is optional. It is not mandatory for the medical institution to report to your employer; it is for your personal benefit. Do you experience any difficulties at work due to dysmenorrhea, premenstrual syndrome (PMS), menopause symptoms, or other female-specific health issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	
血液 ① [:] R L ② [:] ③ [:] <input type="radio"/> 未検査		【特定健診・詳細項目の実施理由】 貧血 診察(貧血) <input type="checkbox"/> 111 既往歴(貧血) <input type="checkbox"/> 112 心電図 血圧(140/90) <input type="checkbox"/> 121 自覚症状(脈の乱れ) <input type="checkbox"/> 122 診察(不整脈) <input type="checkbox"/> 123 眼底 血圧(140/90) <input type="checkbox"/> 131 血糖/A1c(126↑6.5↑) <input type="checkbox"/> 132 前年度血糖(126↑6.5↑) <input type="checkbox"/> 133 CRE 血圧(130/85) <input type="checkbox"/> 141 血糖/A1c(100↑5.6↑) <input type="checkbox"/> 142 前年度結果 空腹時血糖 随時血糖(食後時間)	
心電図 <input type="checkbox"/> 済 <input type="checkbox"/> 未		保健指導 <input type="checkbox"/> 保指 <input type="checkbox"/> 特保	
眼底 右 <input type="checkbox"/> 済 <input type="checkbox"/> 左 <input type="checkbox"/> 済 <input type="checkbox"/> 未		便潜血検査 バーコード貼付位置 (1日目 青ラベル)	
眼圧 右 <input type="checkbox"/> 左 <input type="checkbox"/> 未		便潜血検査 バーコード貼付位置 (2日目 赤ラベル)	
血液検査		尿検査	

Contract organization Affiliation, etc	
Zip Code Address	

0 1 1

※ If there is any error in personal information on the left (organization, name, etc), please correct.

個人番号	
受診券整理番号	有効期限
保険者番号	
被保険者記号	
被保険者番号	枝番

<Requests regarding the medical examination >
I understand the "Explanation of how personal information is handled" below and the "Requests before undergoing a health check" on the back, and will undergo the checkup.

Name	
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Explanation of handling of personal information
The Mie Prefectural Health Management Center (hereinafter referred to as "the Center") comply with related laws and guidelines such as "Law on the Protection of Personal Information", the same "Law on Enforcement Order", and the "Guidelines for Appropriate Handling Personal Information in Medical and Nursing Care Businesses", stipulated by the Ministry of Health, Labor and Welfare, and we collect your name, date of birth, address, health insurance number, company name, etc. obtained in the process of undergoing various examinations and health checkups. The personal information, including health information such as examinations results, will be used for the following purposes:

- Purpose of use of personal information
 - For implementation of medical examinations and tests to understand health status
 - For reporting the results to examinees and outsourcers (local governments, businesses, health insurance associations, etc).
 - To claim for medical examination/examination fees
 - For accurate control of medical examinations and tests
 - For health instructions
- Providing personal information
 - To respond when required, in collaboration with the person in charge, i.e. of the business owner, industrial physician, or public health nurse.
 - To respond when required, in collaboration with referral to medical institutions, etc.
 - When seeking the opinions and advice of external specialists, etc.
 - In accordance with legal regulations.
 - For the purpose of improving academic/educational/research of medicine/medical care, etc. (In this case, personal information will be used after being completely anonymized.)
 - Results will be reported to the entrusting agency (local government, business company, health insurance association, etc.) within the scope of the agreement between the individual and the entrusting agency. (In particular, if there has been no agreement between the outsourcing company and you, and there is no request from them, we will report all results to the outsourcing party).
- Disclosure/correction of personal information
If the customer requests disclosure or correction of his/her personal information, our center will confirm the content without delay and respond in accordance with our "personal information protection regulations".
- Entrustment of personal information
Our center outsources part of examination tasks, information system management, equipment and system maintenance management, and waste disposal operations to outside companies. As for outsourcing, we select appropriate business operators and conduct appropriate management and supervision regarding the protection of personal information through contracts, etc.

※Be sure to put a circle in the box below with a pencil (mechanical pencil). Do not put out of the box.

◆About driving cars	
Do you usually drive a car for commuting or work? If you answered "Yes," please answer the following questions ① to ⑤.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
① I have lost my consciousness, within the past 5 years, due to illness (including symptoms associated with the treatment of illness) or without clear cause.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
② Within the past 5 years, I have been temporarily unable to move all or part of my body as a result of the illness.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
③ Within the past 5 years, I have fallen asleep during daytime activities despite getting enough sleep, more than 3 times per week.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
④ Within the past year, I have experienced any of the following: • I have repeatedly drunk alcohol and I have had alcohol in my body for more than 3 days, for more than 3 times. • I have consumed alcohol more than 3 times despite being advised by the doctor to stop drinking to treat my illness	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
⑤ I have been advised by a doctor to refrain from obtaining a driver's license or driving due to illness	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No

※ This paper will be processed by computer, so please do not get it dirty or roll it.

[For those who wish to undergo gastric cancer risk evaluation (ABC classification)]
If any of the following apply to you, the check-up cannot be performed because you may not get correct results.]

■ Those who have undergone eradication treatment for *Helicobacter pylori* ■ Those with obvious upper gastrointestinal symptoms
■ Those undergoing treatment for upper gastrointestinal diseases ■ Those taking proton pump inhibitors
■ Those with renal failure

Do you wish to take the ABC classification after you understand and agree to the above?
 ◀ Yes, I do. ▶ No, I don't.

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公益財団法人 三重県健康管理事業センター
健診センター サンテ
TEL 059-228-4502
2011-20250401

*** Questionnaire items ***

※Please fill out the questionnaire items in advance.

※Be sure to put a circle in the box with a pencil (mechanical pencil).

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◆Current medical history and past history	none <input type="checkbox"/>	◆Subjective symptoms (※Symptoms within the past month).	Not applicable <input type="checkbox"/>
Disease name	None Cured Untreated Follow-up	<input type="checkbox"/> ◀ Weight loss/gain	<input type="checkbox"/> ◀ Irregular pulse
Blood hypertension	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Loss of appetite or increased appetite	<input type="checkbox"/> ◀ Unpleasant symptoms in the abdomen.
Diabetes	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Chronic headache	<input type="checkbox"/> ◀ Abnormal bowel movements such as diarrhea and constipation.
Liver disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Tinnitus/Hearing impairment	<input type="checkbox"/> ◀ Blood in stool
Dyslipidemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Decreased vision/Eye strain	<input type="checkbox"/> ◀ Abnormal urinary frequency/Abnormal urination.
Angina pectoris, Myocardial infarction, etc.	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Frequent cough and phlegm	<input type="checkbox"/> ◀ Shoulder/Lower back/Knee pain
Others heart diseases ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Blood in phlegm	<input type="checkbox"/> ◀ Numbness in limbs
Cerebrovascular disease ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Dry mouth	<input type="checkbox"/> ◀ Allergy symptoms
Respiratory disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ Shortness of breath/Palpitations	<input type="checkbox"/> ◀ Others ()
Chronic renal (kidney) disease/Renal kidney failure/ Dialysis	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	◆Lifestyle (smoking/drinking)	◆Employment status Not applicable <input type="checkbox"/>
Other renal diseases ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Smoking (Including heated tobacco)	Work system at current workplace
Digestive diseases	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ ① Don't smoke	<input type="checkbox"/> ◀ ① Full-time day shift
Anemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ ② Stopped	<input type="checkbox"/> ◀ ② Full-time night shift
Gout/Hyperuricemia	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ ③ Currently smoking	<input type="checkbox"/> ◀ ③ Shift system
Mental disease	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Those answering questions ② or ③, please indicate the number of cigarettes you smoke per day and the number of years you have been smoking.	Average working hours per day for the most recent month
Ophthalmological diseases ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> × <input type="checkbox"/> = <input type="checkbox"/>	<input type="checkbox"/> ◀ ① Less than 6 hours
Visual impairment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Daily average number of years of smoking Smoking index	<input type="checkbox"/> ◀ ② Less than 6-8 hours
Ear disease ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Drink alcohol	<input type="checkbox"/> ◀ ③ Less than 8-10 hours
Hearing impairment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ ① Don't drink alcohol	<input type="checkbox"/> ◀ ④ More than 10 hours
Others ()	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> ◀ ② Stopped	Average number of working days per week in the most recent month
◆Current medical history/past history.	Under treatment...Using therapeutic drugs and going to the hospital. Cured...The disease has been completely cured. Untreated... Not attending hospital despite doctor's instructions. Follow-up observation...No therapeutic drugs are used, but the patient visits the hospital regularly.	Those answering questions ③ to ⑧, please respond accordingly.	<input type="checkbox"/> ◀ ① Less than 3 days
◆Approximate amount : 1 cup of sake = (15% alcohol, 180ml) Beer (5% alcohol, 500ml), Shochu (25% alcohol, 110ml). Wine (14% alcohol, 180ml), Whiskey (43% alcohol, 60ml) Canned Chu-Hi (5% alcohol, 500ml, 7% alcohol, 350ml)		Average alcohol consumption	<input type="checkbox"/> ◀ ② Less than 3-5 days
		<input type="checkbox"/> ◀ ③ Less than 1 day per month	<input type="checkbox"/> ◀ ③ 5 days
		<input type="checkbox"/> ◀ ④ 1-3 days per month	<input type="checkbox"/> ◀ ④ More than 6 days
		<input type="checkbox"/> ◀ ⑤ 1-2 days a week	◆Past work experience
		<input type="checkbox"/> ◀ ⑥ 3-4 days a week	Do you have any experience handling heavy objects?
		<input type="checkbox"/> ◀ ⑦ 5-6 days a week	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
		<input type="checkbox"/> ◀ ⑧ Drink every day	Do you have any experience working with dust?
			<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
◆About lifestyle/health consultation			Do you have any work experience that involves strong vibrations?
① My weight has increased by 10 kg or more since I was 20 years old.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
② I have been doing light sweat-inducing exercise for at least 30 minutes at least twice a week for over a year.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		Do you have any experience working with hazardous substances?
③ Walking or engage in equivalent physical activity for at least 1 hour a day in daily life.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
④ Walking faster than other people of the same age and sex.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		Do you have any experience working near radiation?
⑤ What do you feel about the way that you chew your food? (Please answer one from the following.)	<input type="checkbox"/> ◀ I can chew and eat anything. <input type="checkbox"/> ▶ There are parts such as teeth, gums, and bite that may make chewing difficult. <input type="checkbox"/> ▶ I can hardly chew the meal		<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No
⑥ I eat faster than others.	<input type="checkbox"/> ◀ Fast <input type="checkbox"/> ◀ Normal <input type="checkbox"/> ▶ Slow		◆Others (※For women)
⑦ I eat dinner within 2 hours before going to bed 3 or more times a week.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		Are you pregnant?
⑧ Do you consume snacks or sweet drinks in addition to the 3 meals (breakfast, lunch, and dinner) of the day?	<input type="checkbox"/> ◀ Every day <input type="checkbox"/> ◀ Sometimes <input type="checkbox"/> ▶ Almost never		<input type="checkbox"/> ◀ Pregnant
⑨ I skip breakfast 3 or more times a week.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		<input type="checkbox"/> ◀ Possibly pregnant
⑩ I am well-rested through sleep.	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		<input type="checkbox"/> ◀ No
⑪ Have you ever received specific health instructions regarding improving your lifestyle habits?	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		Are you in your menstrual period?
⑫ Do you want to improve your lifestyle habits such as exercise and eating habits? (Please answer one from the following.)	<input type="checkbox"/> ◀ I have no intention of improving it. <input type="checkbox"/> ▶ I have intention of improving it. (approximately within 6 months)		<input type="checkbox"/> ◀ Yes
	<input type="checkbox"/> ◀ I am planning to improve my condition in the near future (approximately within a month), and I am starting to do so, little by little.		<input type="checkbox"/> ▶ No
	<input type="checkbox"/> ◀ I am already working on improvements. (less than 6 months). <input type="checkbox"/> ▶ I am already working on improvements. (more than 6 months)		
⑬ Is there any advice that you would like to receive about your health?	<input type="checkbox"/> ◀ Yes <input type="checkbox"/> ▶ No		