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

2024 Toyohashi Respiratory (Tuberculosis/Lung Cancer) Questionnaire 令和6年度（2024年）肺（結核・肺がん）検診受診券

1	Have you received the lung examination in the past?		No	Yes	Date of previous examination ☐☐ (YY) 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 lung diseases 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 ☐☐☐☐ (YY)

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.

2024 Toyohashi Stomach Cancer Questionnaire 令和6年度（2024）胃がん検診受診券 □please fast on the day of your examination

1	Have you received a stomach cancer examination in the past?		No	Yes	Date of previous examination ☐☐ (YY) 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

2024 Toyohashi Colon Cancer Questionnaire 令和6年度（2024年）大腸がん検診受診券

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

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

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

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

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 of previous exam: Normal • Follow-up exam needed (examination required abnormal findings Y/N)
2	Do you have (or have had) any cervical conditions/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 Childbirth ☐ times Age at last child's birth ☐ years old 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 • Moderate • 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.

1	Have you undergone any breast cancer screening tests?	No	Yes	This is my ☐ time Date of previous examination ☐ (YY) Type of test undergone Ultrasound • Mammography Where did the screening test take place? （ ） Results of previous exam: Normal • Follow-up exam needed (examination required 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 □ (YY) 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	Who （ ）
		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