# National Health Insurance

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|---|---|---|---|
| Health Examination Ticket Number | | Notification Number | |
| Name (in kana) | | | |
| Age | y/o (Age as of 2026/03/31) | Sex | |
| Date of Birth | | | |
| **Valid until** | | | |

**Toyohashi National Health Insurance Specific Health Checkup Ticket for the 2025 Fiscal Year**

Issued

**・Please read "Specific/General Health Checkup Information" for the 2025 Fiscal Year included in the same envelope.**

**※Please check the period of validity on this ticket above.**

**・Please bring the following with you:**

☐Specific Health Checkup Ticket

☐Something to confirm enrollment in Toyohashi City National Health Insurance (My Number card linked to your health insurance, "Health Insurance Qualification Confirmation Form" (資格確認書, *shikaku kakunin-sho*), valid health insurance card)

＊If you will be having a combined Ningen Doc exam (included JA Toyohashi Ningen Doc exams) or receiving your checkup together with a group, you may have to bring different documents, etc.

Outpatients currently receiving treatment can also be examined

**・Filling out your health checkup ticket:**

Please fill out the questionnaire on the back of this paper. **If you will be receiving your checkup together with a group,** you only need to write your phone number(s) on the back of this page. You don't need to fill in the other fields.

※For clinic/medical institution use only.

| | | | | | |
|---|---|---|---|---|---|
| Exam Date | Mo. Day | | National Health Insurance Card Number | | |
| Body Measurements | Height cm | Weight kg | BMI | AC (abdominal circumference) cm | |
| Objective Symptoms | No ☐ Yes ☐ | | Blood Pressure | SBP / DBP mmHg | |
| Urinalysis | Protein − ☐ ± ☐ ＋ ☐ ＋＋ ☐ ＋＋＋ ☐ | | Sugar − ☐ ± ☐ ＋ ☐ ＋＋ ☐ ＋＋＋ ☐ | Period ☐ | Kidney ☐ |

**Detailed Health Examinations**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Reason for Exam | Anemia | Past history ☐ | Potential ☐ | | | | |
| | Electro-cardiogram | Blood pressure ☐ | Individuals whose SBP was 140 mmHg and over/DBP was 90 mmHg and over in the current year's checkup results. | Potential arrhythmia ☐ | | | |
| | Eye Fundus | Blood pressure ☐ | Individuals whose SBP was 140 mmHg and over/DBP was 90 mmHg and over in the current year's checkup results. | Blood sugar ☐ | Individuals whose blood sugar was 126mg/dℓ or over with an empty stomach, or individuals with an HbA1c (NGSP) of 6.5% and over, or those whose blood sugar is at or above 126mg/dℓ at all times. (For indivudals who received their checkup at a medical institution, refer to this year's checkup results. For individuals who did their checkup with a group, refer to last year's checkup results.) | | |
| | Anemia | No ☐ Yes ☐ | Electro-cardiogram | No ☐ Yes ☐ | Eye Fundus | No ☐ Yes ☐ | Name of requested clinic / Code |

**Observations**

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Electro-cardiogram | Code | Eye Fundus | Code | Scheie Classification | S0 | S1 | S2 | S3 | S4 | H0 | H1 | H2 | H3 | H4 | | | | | |
| | Necessary to recommend follow-up exams? | No ☐ | | | | | | | | | | | | | | | | | | |
| | | Yes ☐ | BP ☐ 1 | Fats ☐ 2 | BG ☐ 3 | Liver ☐ 4 | Kidney ☐ 5 | UA ☐ 6 | Anemia ☐ 7 | ECG ☐ 8 | FO ☐ 9 | Other | | | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Clinic Name 医院名 | | Clinic Code 医院コード | | Physician Name 医師氏名 | | Class 種別 |

**国保61**

■For patient use (Please fill out the following information). Information may be used for health services, such as sending SMS messages to cell phone numbers to recommend health checkups, etc.

| Phone Number (Cell) | □□□ –□□□□–□□□□ | Phone Number (Home) | □□□□ – □□ – □□□□ |
|---|---|---|---|

| | | | Please draw a diagonal line ( / ) through the applicable box |
|---|---|---|---|
| 1 | Do you use any of the following medicines (1 - 3) regularly? | | |
| 1 | 1 Medicine to lower blood pressure? | | Yes / No |
| 2 | 2 Medicine or insulin injections to lower blood sugar levels? | | Yes / No |
| 3 | 3 Medicine to lower cholesterol or neutral fats/triglycerides? | | Yes / No |
| 4 | Have you been told by a doctor that you suffered/are suffering from a stroke (cerebral hemorrhage, cerebral infraction, etc.) or have received treatment for a stroke? | | Yes / No |
| 5 | Have you been told by a doctor that you suffered/are suffering from heart disease (angina pectoris, myocardial infarction/heart attack, etc.) or have received treatment for heart disease? | | Yes / No |
| 6 | Have you been told by a doctor that you are suffering from chronic kidney disease or kidney failure, or have received treatment (dialysis, etc.) for chronic kidney disease or kidney failure? | | Yes / No |
| 7 | Have you ever been told by a doctor that you are anemic? | | Yes / No |
| 8 | Are you currently a habitual smoker?<br>Condition 1: You've smoked for at least 1 month recently<br>Condition 2: You've smoked for a period of 6 months or more at some point in your life and/or have smoked at least 100 combined cigarettes in your life. | ①Both 1 and 2 apply<br>②Only 2 applies<br>③I don't smoke Or neither ① nor ② applies | ① / ② / ③ |
| 9 | Have you gained 10kg or more since turning 20? | | Yes / No |
| 10 | Have you been doing light exercise for at least 30 minutes twice or more per week for one year or longer? | | Yes / No |
| 11 | Have you been walking for at least one hour during your daily activities or doing physical activitity equivalent to walking for at least one hour daily? | | Yes / No |
| 12 | Do you tend to walk faster than those of the same age as you? | | Yes / No |
| 13 | Which of the following best applies to you when chewing food? | ①I can eat and chew all kinds of food.<br>②I am concerned about my teeth, gums, or bite, and it is sometimes difficult to chew food.<br>③I cannot chew most foods. | ① / ② / ③ |
| 14 | Do you tend to eat more quickly than others? | | Fast / Normal / Slow |
| 15 | In a one week period, do you eat dinner within 2 hours of going to bed three or more times? | | Yes / No |
| 16 | Do you snack on sweet foods or drinks in between proper meals (breakfast, lunch, and dinner)? | | Daily / Once in a while / Almost never |
| 17 | Do you skip breakfast 3 or more times in a week? | | Yes / No |
| 18 | How often do you drink alcohol (sake, shōchū, beer, hard alcohol, etc.)? (Please select only one answer) *("Quit" means you have not consumed alcoholic beverages in at least 1 year after habitually drinking at least once/month in the past) | | Daily / 5-6 days a week / 3-4 days a week / 1-3 days a month / Less than once/ month / I Quit / Don't drink/can't drink |
| 19 | On days that you drink alcohol, how many alcoholic drinks do you drink? (Please select only one answer)<br>A one-drink measurement is based on one "gou," or 180ml, of 15% alcohol sake, which is also approximately:<br>One 500ml bottle of beer (5% alcohol), 110ml of shōchū (25%), 180ml of wine (14%), one double-shot (60ml) of whisky (43%), or a 500ml (5%) or 350ml (7%) can of chūhai. | | Less than 1 drink / 1-2 drinks / 2-3 drinks / 3-5 drinks / 5 or more drinks |
| 20 | Do you feel well-rested after sleeping? | | Yes / No |
| 21 | Do you want to improve your current lifestyle (exercise, eating habits, etc.)?<br>Please choose one from ① to ⑤ | ①No, I'm not planning on it.<br>②Yes, within the next six months.<br>③Yes, wihtin the next month, and I am already slowly improving my lifestyle.<br>④I have already begun improving my lifestyle (within the past six months).<br>⑤I have already begun improving my lifestyle (for six months or more). | ① / ② / ③ / ④ / ⑤ |
| 22 | Have you ever received health guidance related to lifestyle improvement? | | Yes / No |
| 23 | When was the last time you ate a meal? | | Within 3.5 hrs / 3.5 - 10 hrs ago / 10+ hrs ago |
| 24 | Noticeable symptoms | 1 None / 2 Headache / 3 Dizziness / 4 Ringing in ears / 5 Chest pain / 6 Heart palpitations / 7 Dry mouth / 8 Sudden weight loss / 9 Swelling / 10 Get tired easily / 11 Numbness in hands/feet / 12 Other ( ) | |
| 25 | Please tell us where you found out about this "specific health checkup" (select all applicable responses) | 1."Cancer screening/specific health checkup" pamphlet / 2.Flyer distributed by your residents' association / 3.Flyer from a medical facility / 4.A different flyer / 5. Poster / 6.Postcard/text message / 7.YouTube Ad / 8.Video at a train station/medical facility, etc. / 9. Information display at City Hall / 10.City's official website / 11.I didn't see anything about this checkup / 12. Other | |

| Insurer | | |
|---|---|---|
| | Address | 1 Imahashicho, Toyohashi, Aichi |
| | Telephone | 0532 - 51 - 2293 |
| | Insurer Number | 00230029 |
| | Insurer Name | Toyohashi City |
| Payment Agency Number | | 92399021 |
| Payment Agency Name | | Aichi Prefecture National Health Insurance Federation |

**Inquiries**
**Toyohashi City Hokenjo Health Center**
**Health Promotion Division**
**Nakahara-100 Nakanocho, Toyohashi, Aichi, 441-8539**
**(Inside Hoippu)**
**TEL (0532) 39 - 9141**
**FAX (0532) 38 - 0770**