「(英語版) 胃がん検診記録票」

日本語の検診記録票への記載の際にご活用ください。

Utsunomiya City　Stomach Cancer Screening Record Form

Cost category	1	General	2	Exemptions	Checkup date	Year	Month	Day
Appointment ticket no.						2		

Address	Name	Male　Female
Utsunomiya City Phone no.　(　　)	Date of birth ____ Year _____ Month _____ Day　___ years old	

Please read the information on the back and answer the following questions. (Please fill in the applicable information or circle the applicable content.)

Consent form	○Having understood the purpose of the stomach cancer screening, I consent to undergo the screening. [Test method:] 1. Direct x-ray imaging　2. Endoscopy Name _____ (Please sign here.)				
	○If findings are detected during an endoscopy, is it acceptable to perform a gastric biopsy? (This procedure is covered by insurance, but you will be responsible for the out-of-pocket costs.) 1. Yes　2. No				
Medical questions	Past & present medical history	Have you ever had stomach cancer?	No	Yes	(_____ (year) _____ (years old))
		Have you ever undergone surgery?	No	Yes	1. Stomach and duodenum　2. Gallbladder　3. Pancreas 4. Nasal cavity　5. Other ( )
		Are you currently being treated for a stomach condition (such as a stomach ulcer)?	No	Yes	1. Gastric ulcer　2. Duodenal ulcer 3. Gastric polyp　4. Other ( )
		Do you currently have any of the following symptoms?	1 No	2 Yes	1. Weight loss　2. Loss of appetite　3. Abdominal pain 4. Heartburn　5. Belching　6. Feeling of fullness 7. Food getting stuck in throat 8. Other ( )
		Are you currently being treated for any of the following conditions?	No	Yes	1. Hypertension　2. Glaucoma 3. Heart disease　4. Benign prostatic hyperplasia 5. Hyperthyroidism　6.Diabetes 7. Asthma　8. Other ( )
		Do you currently have any of the following diseases?	No	Yes	1. Heart disease (such as angina or arrhythmia)　2. Sinusitis 3. Nasal polyps　4. Allergic rhinitis 5. Other ( )
		Are you currently taking any anticoagulants (such as Warfarin or Bufferin)?	No	Yes	(Name of medicine:)
		Do you have any medicine allergies?	No	Yes	(Name of medicine:)
	Lifestyle habits	Do you smoke?	No	Yes	1. I smoke now　2. I used to smoke, but quit
		Do you wear dentures?	No	Yes	
		Have you ever had dental work done under anesthesia?	No	Yes	1. There was a problem 2. There were no problems

	Medical history, screening history, etc.	Has anyone in your family ever had stomach cancer?	No	Yes	1. Biological father/mother 2. Spouse 3. Child 4. Brother/sister 5. Grandfather/grandmother
		Have you ever undergone stomach cancer screening?	No	Yes	Please provide information about the most recent test. 1. Where did you have testing done? (Municipality / Workplace /Comprehensive health screening / Other _____) 2. Screening method (X-ray test / Endoscopy Blood test (Pepsinogen test, Helicobacter pylori test) 3. Screening period (_____ (year) _____ (years old))
		Have you ever been tested for H. pylori?	No	Yes	Please provide the test results. 1. Negative 2. Positive (Treated/Untreated) 3. Unknown

Screening results	1	No stomach cancer	①	Findings indicate no chronic gastritis.
			②	Chronic gastritis is present.
			Currently, there are no findings indicative of stomach cancer or suspected stomach cancer. Stomach cancer can still develop even in patients who have undergone treatment to eradicate H. pylori. We recommend that you continue to undergo regular screenings.	
	2	Further Testing Required Retest	The results of this test indicate findings that require further testing or a retest. Since further testing is necessary, please visit a medical facility.	
	3	Treatment Required	The results of this test indicate findings that require treatment. Since treatment is necessary, please visit a medical facility.	
	4	Other		

Name of medical institution & physician	

※Section for medical professionals to fill in

Blood pressure:	mmHg	Remarks	