

# Latter-stage Elderly Healthcare Insurance

Health Examination Ticket Number		Notice number	
Name (in kana)			
Age		y/o	Sex
(As of 2026/03/31)			
Date of Birth			
Valid until			

Latter-stage Elderly Healthcare 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 bring the following with you:

☐ Health Checkup Ticket

☐ Something to confirm your eligibility for the Latter-stage Elderly Health Insurance system

(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.

• Filling out your health checkup ticket:

Please fill out the questionnaire on the reverse of this page. If you will be receiving your checkup with a group, you only need to fill out the phone number (TEL) field.

If you have any medical history or concerns, please discuss them directly with your doctor. This info will not appear on your checkup results.

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

※For clinic/medical institution use only.

Checkup Date	Mo. Day		Latter-stage Elderly Health Insurance Card Number															
Body Measurements	Height		Weight		BMI													
Observable Symptoms	No	Yes			Blood Pressure	SBP	DBP	mmHg										
Urinalysis	Protein	—	±	+	++	+++	Sugar	—	±	+	++	+++	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							
		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	Fats	BG	Liver	Kidney	UA	Anemia	ECG	FO	Other							
Clinic Name	Clinic Code		Physician Name		Class		後期高齢63											

■For patient use (Please fill out the following information)		TEL	— —
		Please draw a diagonal line (/) through the applicable box <input type="checkbox"/>	
1	How would you describe your current health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Normal <input type="checkbox"/> Not good <input type="checkbox"/> Terrible	
2	Are you satisfied with your daily life?	<input type="checkbox"/> Yes <input type="checkbox"/> Somewhat <input type="checkbox"/> Not really <input type="checkbox"/> Not at all	
3	Do you eat three proper meals per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	Compared to half a year ago, has it become more difficult for you to eat hard foods*? *such as <i>saki ika</i> (dried squid) or <i>takuan</i> (pickled radish)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5	Do you sometimes choke when drinking tea, soup, or other fluids?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6	Have you lost 2 kg or more within the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7	Has your walking pace gotten slower compared to before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8	Have you fallen down in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9	Do you exercise (walk, etc.) at least once per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10	Are you told by other people that you are forgetful or always ask the same thing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11	Do you sometimes forget what day and/or month it is?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12	Do you smoke tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I quit smoking	
13	Do you go out at least once per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14	Do you normally interact with family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15	Is there someone close to you that you can talk to when you aren't feeling well?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16	When was the last time you ate a meal?	<input type="checkbox"/> Within 3.5 hours <input type="checkbox"/> 3.5-10 hours ago <input type="checkbox"/> 10+ hours ago	

I n s u r e r	Address	1-chome-6-5 Izumi, Higashi-ku, Nagoya, Aichi
	Telephone	052-955-1205
	Insurer Number	39232012 (Toyohashi City)
	Insurer Name	Aichi Prefecture Latter-stage Elderly Healthcare Association
	Payment Agency Number	92399021
	Payment Agency Name	Aichi Prefecture National Health Insurance Federation

**Inquiries**  
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