

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

2026 Toyohashi Respiratory (Tuberculosis/Lung Cancer) Questionnaire 令和8年度(2026年)肺(結核・肺がん)検診受診券

Patients currently undergoing treatment or follow-up treatment for lung disease are not eligible for this exam.

Group medical exam don't need to be recorded

1	Are you currently undergoing treatment for any respiratory illness?	No	Yes	Name of illness ()	Symptoms	Cough	No	Yes		
2	Have you experienced any lung diseases in the past?	No	Yes	When? <input type="text"/> <input type="text"/> age <input type="checkbox"/> Pulmonary Tuberculosis <input type="checkbox"/> Lung Cancer <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pneumoconiosis <input type="checkbox"/> Pleuritis <input type="checkbox"/> Others ()		6	Phlegm	No		Yes
3	Have you received the lung examination in the past?	No	Yes	Date of previous examination <input type="text"/> (YY) Place received () Results of previous exam: <input type="checkbox"/> Normal • Abnormal/No follow-up exam • Follow-up exam needed (examination required abnormal findings Y/N)		7	Coughing up blood in the past 6 months	No		Yes
4	Are any of your family members affected by cancer?	Lung	No	Yes	Relation ()	Do you smoke?	1 Not at all <input type="checkbox"/>	At what age did you start smoking? <input type="text"/> <input type="text"/> age		
		Others	No	Yes	Relation () Type of cancer ()		2 I quit <input type="checkbox"/>	At what age did you stop smoking? <input type="text"/> <input type="text"/> age		
5	Have you ever worked under the conditions listed in the following?	No • unsure	Yes	Manufacturing/processing using asbestos Ceramics Metalworking Other () Period <input type="text"/> (YY)	9	Are you pregnant? (Females only)	No	Yes		
							8	If you smoke, do you want to:		quit immediately <input type="checkbox"/>
10	Height <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm Weight <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kg									

Patients currently undergoing treatment or follow-up treatment for large intestine/colon disease, etc., are not eligible for this exam.

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		

Colon Cancer Screening Test Results	
Your result is marked by a O	
The result of your occult blood stool exam is as follows.	
<input type="checkbox"/>	Normal (Fecal Occult Blood Test Negative) No abnormalities were detected in this screening test. Most cancers in the early stages do not have any noticeable symptoms. We recommend that you take the cancer exam at least once a year even if you do not have any symptoms.
<input type="checkbox"/>	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.

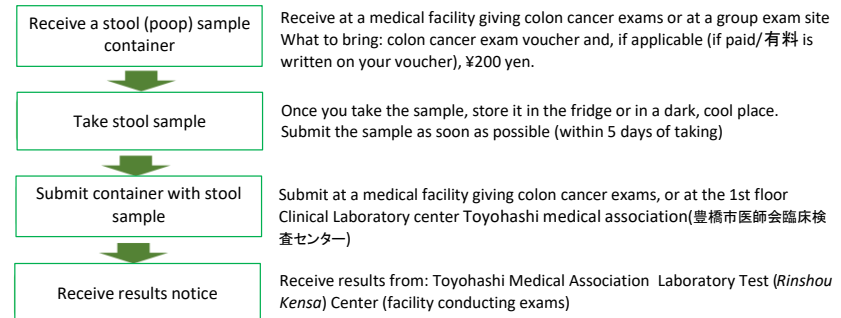
※For the examination center use only

検査年月日	令和 年 月 日
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<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	Do you have an illness, etc., of the large intestine (colon), or have you had one in the past?	No	Yes	Currently receiving medical treatment Finished receiving treatment around (year) Name of illness, etc. ()	
2	Have you received a colon cancer examination in the past?	No	Yes	Date of previous examination (YY) Results of previous exam: (examination required abnormal findings Y/N) Normal • Follow-up exam needed	
3	Are you currently affected by the following symptoms?	No	Yes	Bloody stools Diarrhoea Constipation	
4	Do you suffer from hemorrhoids?	No	Yes		
5	Are any of your family members affected by cancer?	Colon	No	Yes	Relation ()
		Others	No	Yes	Relation () Type of cancer ()

< Getting a colon cancer exam >



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

Patients currently undergoing treatment or follow-up treatment for stomach illness/gastrointestinal disorders are not eligible for this exam.

Group medical exam don't need to be recorded

1	Were you/Are you currently affected by the following illnesses?	No	Yes	Stomach Cancer	Stomach Ulcer	5	Have you undergone treatment for helicobacter pylori infection?	No Unsure	Yes	Recovered fully from infection (When?)	
				Duodenal Ulcers	Stomach Polyp					Did not recover fully from infection	
				Stomach Spasms	Chronic Gastritis	6	Have you ever had abdominal surgery?	No	Yes	Name of illness and when? ()	
				Gall Stones	Others ()					Unsure	
				Heart Disease	Prostatic Hypertrophy	7	Are any of your family members affected by cancer?	Stomach	No	Yes	Relation ()
				Glaucoma	Thyroid Gland Disease						
2	Have you received a stomach cancer examination in the past?	No	Yes	Date of previous examination () (YY)	Exam method: Abdominal X-ray • Gastroendoscopy	7	Are you pregnant? (Females only)	No			Yes
				Results of previous exam	Normal • Abnormal • Follow up exam needed			Type of cancer ()			
3	Symptoms	No	Yes	Sensation that food is stuck in your		8					
				Nausea	Abdominal Pain		No • Yes				
				Bloatedness							
				Vomiting blood, Blood in the stool							
				Others ()							
4	Have you undergone helicobacter pylori tests?	No Unsure	Yes	Results (Positive • Negative • Unsure)							

Patients undergoing treatment or follow-up treatment for conditions of the cervix are not eligible for this exam.

Group medical exam don't need to be recorded

1	Do you have (or have had) any cervical conditions/disorders?	No	Yes	Currently under treatment () (M) (MM) Date of the end of treatment ()	5	Have you received the HPV vaccine (cervical cancer vaccine)?	No	Yes	First shot () (YY)	
				Name of disorder ()					Number of shots received () times	
2	Have you received examination for cancer in the uterus in the past?	No	Yes	This is my () time Date of previous examination () (YY)	6	Have you ever had sexual intercourse?	Yes		No	
				Results of previous exam: Normal • Follow-up exam needed						
3	Symptoms Pain	No	Yes	Menstrual cramps • Abdominal pain • Back pain • Others	7	Are you currently pregnant?	No	Yes	How far along? () weeks	
				Colour (Fresh blood • Light spotting • Brown spotting • Others)					※You cannot receive this examination, as you receive it during prenatal checkup.	
	Bleeding/ Discharge in last 6 months	No	Yes	Flow (Heavy • Moderate • Light)	8	Pregnancy/ Childbirth	Pregnancy () times	Childbirth () times	Age at last child's birth () years old	
				When? Since () months ago (Once • Sometimes • Always)			Natural childbirth () times	Caesarean section () times		
				Does it occur after the following? (After intercourse • After bowel movements • During urination • Irregularly • Others)	9	Are you currently taking the following?	No	Yes	IUD • Birth Control Pill • Other hormonal contraceptives	
4	Menstrual Cycle			Age of first period () years old	10	Do you have any blood relatives that had cancer?	Uterine cancer	No	Yes	Who ()
				Date of last period () (MM) () (DD) to () (DD)						Who ()
				Regular • Irregular			Other	No	Yes	type of cancer (cervical cancer/endometrial cancer)
				Flow (Heavy • Medium • Light)						type of cancer (cervical cancer/endometrial cancer)

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.

2026 Toyohashi Breast Cancer Questionnaire 令和8年度(2026年)乳がん検診受診券

Patients currently undergoing treatment or follow-up treatment for breast conditions are not eligible for this exam.

Group medical exams don't need to be recorded

You cannot receive Breast Cancer examination if a) you are pregnant (or suspect you may be pregnant), b) breastfeeding, c) it has been less than 6 months since you stopped weaning your child, or d) fall under the category 8 below.


1	Were you affected by any breast disorders?	No	Yes	• Breast Cancer • Mastopathy • Others () Have you had surgery on your breasts? No • Yes	4	Menstrual Cycle	No	Yes	Age of menopause <input type="text"/> years old Date of last period <input type="text"/> (MM) <input type="text"/> (DD) - <input type="text"/> (DD)
					5	Pregnancy/Childbirth	Are you currently pregnant? (No • Yes) Pregnancy <input type="text"/> times Childbirth <input type="text"/> times		
2	Have you undergone any breast cancer screening tests?	No	Yes	Date of previous examination <input type="text"/> (YY) Results of previous exam: Normal • Follow-up exam needed	6	Are you breastfeeding?	No	Yes	After birth <input type="text"/> months
					7	Are any of your family members affected by Breast cancer?	No	Yes	Relation ()
3	subjective symptoms				8	Have you undergone for any of the following?	No	Yes	<input type="checkbox"/> Pacemaker implantation <input type="checkbox"/> V-P(Ventriculoperitoneal shunting) <input type="checkbox"/> Chest Port insertion <input type="checkbox"/> Breast implants
	Pain	No	Yes	Right Left From when? ()					
	Lumps	No	Yes	Right Left From when? ()					
	Others ()	No	Yes	Right Left From when? ()					

2026 Toyohashi Prostate Cancer Questionnaire 令和8年度(2026年)前立腺がん検診受診券

Patients currently undergoing treatment or follow-up treatment for prostate disease are not eligible for this exam.

1	Were you affected by any prostate disease?	No	Yes	Prostate gland enlargement • Inflammation of the prostate	
2	Have you received a Prostate cancer examination in the past?	No	Yes	Date of previous examination <input type="text"/> (YY) Previous numerical value <input type="text"/>	
3	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	
4	Do you have any blood relatives that had cancer?	Prostate cancer	No	Yes	Grandfather/father/brothers
		Colon Cancer	No	Yes	Who ()
		Breast	No	Yes	Who ()
		Ovarian cancer	No	Yes	Grandmother/mother/sisters

Patients currently undergoing treatment or follow-up treatment for large intestine/colon disease, etc., are not eligible for this exam.

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Address			
Name	フリガナ ()		
Date of birth		years old	
No.			
Tel:			
Fee	Free of charge	Sex	
Where did you receive the sample container from?	Medical institutions with hepatitis virus examination		
	(The participating medical facilities will be listed on the Toyohashi city homepage)		
	※This voucher is not valid for examinations at the Toyohashi City Health Center.		
医院コード		検査月日	
医院名			

category	<input type="checkbox"/>	examined at the same time as specific health check-up	<input type="checkbox"/>	standalone examination
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What is Hepatitis Virus?
A disease where liver cells are destroyed by viral hepatitis infection.

The purpose of Hepatitis Virus examination
As the liver is known as a silent organ, there are rarely any subjective symptoms, even when infected with Hepatitis B or C viruses. Chronic hepatitis can progress to cirrhosis or liver cancer without any symptoms. The goal of regular check-ups is to achieve early detection and treatment.

How many people are infected by Hepatitis Virus in Japan?
It is estimated that there are approximately 1.1 million carriers of the Hepatitis B virus and 0.9 million carriers of the Hepatitis C virus in Japan. However, because there are often no subjective symptoms, it is believed that many people do not realize they are infected.

Recommended for persons who have Toyohashi National Health Insurance or Medical care system for the advanced elderly insurance

If you will have a Specific Health Checkup in a medical institution in Toyohashi, it is recommended to have this examination at the same time. Please be aware that this examination will not be carried out during group checkups.

After understanding the purpose of the exam, do you wish to have the hepatitis virus examination? Yes • No

Name	
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QUESTIONNAIRE

1	Have you ever had any liver disease or were told that your liver functions poorly?	Yes • No
2	Will you be receiving any other medical examinations (health services provided by your medical insurance or any exams required by law, etc.) which include a hepatitis test?	Yes • No
3	Have you ever been tested for hepatitis B or C?	Yes • No
4	Are you currently receiving medical treatment for hepatitis B or C?	Yes • No

※If you answered "Yes" to 2, 3, or 4, you are not eligible for this hepatitis test. However, if you answered "Yes" to 3, and your liver function exam results from your "specific health checkup" (or similar checkup) this year were "abnormal" (異常), then you are eligible.

You need to receive this examination if
 you have received blood transfusions or major surgery,
 you have shared needles/syringes with an infected person,
 you have touched an infected person's blood with an open wound,
 you have had sexual intercourse with an infected person
 you have received tattoos or body piercings.
 Hepatitis viruses are transmitted through blood and body fluids.

What is Hepatitis Virus examination?
 Blood test
 Testing for hepatitis B (antigen HBs), hepatitis C (antibody HCV). (Depending on test results, you will receive a HCV Nucleic Acid Amplification Test.)
【Caution】
 Note that a hepatitis infection may not test positive until approximately three months after exposure. Furthermore, regular liver function tests conducted during general health screenings do not check for the presence of hepatitis viruses.

What do you do if you find out that you have a hepatitis virus infection?

Please visit a medical institution for specialized liver disease for further examination. Those undergoing further examination may be eligible for financial assistance. For details, please consult with the medical institution when you receive your results, or contact Health Promotion Division in Toyohashi Hokenniyo Health Center (Hoippu) (☎39-9136).

This examination is not for individuals currently receiving treatment for eye diseases or those undergoing regular, equivalent eye exams.

1	Have you suffered from, or are you currently undergoing treatment for any of the following?	No	Yes	<input checked="" type="checkbox"/> Cataracts	<input checked="" type="checkbox"/> Glaucoma	<input checked="" type="checkbox"/> Age-related macular degeneration	<input checked="" type="checkbox"/> Others ()
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> High Blood Pressure	<input checked="" type="checkbox"/> Diabetes	<input checked="" type="checkbox"/> Liver disease	<input checked="" type="checkbox"/> Heart disease
				<input checked="" type="checkbox"/> Hyperlipemia	<input checked="" type="checkbox"/> Kidney disease	<input checked="" type="checkbox"/> Allergies	<input checked="" type="checkbox"/> Collagen disease
2	Symptoms	No	Yes	<input checked="" type="checkbox"/> My vision in one eye is blurry and cannot see things clearly like before, even with glasses.	<input checked="" type="checkbox"/> I am very sensitive to light and I see a rainbow-like reflection around the light.		
		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> My vision is getting narrow and I stumble easily.	<input checked="" type="checkbox"/> I see black spots floating in my vision.		
				<input checked="" type="checkbox"/> I have distorted vision and can see a dark gray spot in the center of my vision.	<input checked="" type="checkbox"/> I have diabetes but I have not seen an eye doctor for more than one year.		

●Precautions

- Participating medical facilities (please make an appointment with a medical facility before getting examined)
- Your pupils will be dilated during the exam, so things may appear very bright for a little while following the exam.
Please do not operate motor vehicles (drive), ride a bicycle, etc., for at least a few hours after your exam as it is dangerous.