

<受診券翻訳文>

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

2026 Toyohashi Cervical Cancer Questionnaire

令和8年度(2026年)子宮頸がん検診受診券

【英語】子宮(40歳未満)

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