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

2025 Toyohashi Respiratory (Tuberculosis/Lung Cancer) Questionnaire 令和7年度（2025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（ ）
2	Have you received the lung examination in the past?		No	Yes	Date of previous examination ☐☐ (YY) Place received（ ） Results of previous exam: Normal・Abnormal/No follow-up exam・Follow-up exam needed（examination required / abnormal findings Y/N）
3	Have you experienced any lung diseases in the past?		No	Yes	When? ☐☐ age ☐ Pulmonary Tuberculosis ☐ Lung Cancer ☐ Pneumonia ☐ Pneumoconiosis ☐ Pleuritis ☐ Others（ ）
4	Are any of your family members affected by cancer?	Lung	No	Yes	Relation（ ）
		Others	No	Yes	Relation（ ） Type of cancer（ ）
5	Have you ever worked under the conditions listed in the following?		No・unsure	Yes	Manufacturing/processing using asbestos Ceramics Metalworking Other（ ） Period ☐☐☐☐ (YY)

6	Symptoms			
	Cough	No	Yes	
	Phlegm	No	Yes	
	Coughing up blood in the past 6 months	No	Yes	
7	Do you smoke?	1 Not at all ☐ 2 I quit ☐ 3 Yes ☐		At what age did you start smoking? ☐☐ age At what age did you stop smoking? ☐☐ age How many cigarettes do you smoke in a day? (Please fill in even if you have stopped smoking.) ☐☐ cigarettes How long have you smoked/have been smoking? ☐☐ year
8	If you smoke, do you want to:	quit immediately ☐	quit someday ☐	don't want to quit ☐
9	Are you pregnant? (Females only)	No	Yes	
10	Height ☐☐☐.☐ cm Weight ☐☐☐.☐ kg			

Stomach x-ray pre-examination questionnaire

※If you wish to have a gastroscopy screening instead, please complete the gastroscopy pre-examination questionnaire available at a medical institution.

2025 Toyohashi Stomach Cancer Questionnaire 令和7年度（2025）胃がん検診受診券 □please fast on the day of your examination

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 Duodenal Ulcers / Stomach Polyp Stomach Spasms / Chronic Gastritis Gall Stones / Others（ ） Heart Disease / Prostatic Hypertrophy 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 Results of previous exam Normal・Abrormal/No follow-up exam・Follow up exam needed（examination required / abnormal findings Y/N）
3	Have you ever had abdominal surgery?		No	Yes	Name of illness and when?（ ） ☐☐ years old
4	Are any of your family members affected by cancer?	Stomach	No	Yes	Relation（ ）
		Others	No	Yes	Relation（ ） Type of cancer（ ）
5	Did you feel unwell after receiving the injection for the stomach and intestines xamination?		No	Yes	Brief Description of Symptoms [ ]

6	Have you undergone helicobacter pylori tests?	No・Unsure	Yes	Results（Positive・Negative・Unsure）
7	Have you undergone treatment for helicobacter pylori infection?	No・Unsure	Yes	Recovered fully from infection（When? ） Did not recover fully from infection Unsure
8	Symptoms	No	Yes	Pain in Stomach （on an empty stomach・after eating・regardless） Abdominal Pain Nausea Heartburn Sensation that food is stuck in your （throat・chest・pit of your stomach） Bloatedness Heavy stomach Burp Lack of appetite Acid Reflux Diarrhoea Constipation Black stools Loss of weight Others（ ）
9	Do you consume… Tobacco?	Don't smoke / Quit smoking / Smoke		I smoke (smoked) _____ cigarettes every day. I have been smoking (smoked) for _____ years. ※Please fill out the above even if you already quit smoking.
	Alcohol?	Don't drink / Quit drinking / Drink		Everyday・Sometimes・Rarely
	Coffee?	Don't drink / Drink		Everyday・Sometimes・Rarely
10	Are you pregnant? (Females only)			No・Yes

2025 Toyohashi Colon Cancer Questionnaire 令和7年度（2025年）大腸がん検診受診券

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		

※For the examination center use only

検査年月日	令和	年	月	日

Colon Cancer Screening Test Results

Your result is marked by a O

The result of your occult blood stool exam is as follows.

☐ **Normal（Fecal Occult Blood Test Negative）**
No abnormalities were detected in this screening test.
Most cancers in the early stages do not have any noticable symptoms. We recommend that you take the cancer exam at least once a year even if you do not have any symptoms.

☐ **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 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: Normal・Follow-up exam needed (examination required abnormal findings Y/N)
3	Are any of your family members affected by cancer?	Colon	No	Yes	Relation（ ）
		Others	No	Yes	Relation（ ） Type of cancer（ ）
4	Do you suffer from hemorrhoids?		No	Yes	
5	Are you currently affected by the following symptoms?		No	Yes	Bloody stools Diarrhoea Constipation

< Getting a colon cancer exam >

Receive a stool (poop) sample container	Receive at a medical facility giving colon cancer exams or at a group exam site What to bring: colon cancer exam voucher and, if applicable (if paid/有料 is written on your voucher), ¥200 yen.
↓ Take stool sample	Store the sample in a cool, dark place Submit the sample as soon as possible (within 5 days of taking)
↓ Submit container with stool sample	Submit at a medical facility giving colon cancer exams What to bring: colon cancer exam voucher and stool sample
↓ Receive results notice	Receive results from: Toyohashi Medical Association Laboratory Test (*Rinshou Kensa*) Center (facility conducting exams)

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

2025 Toyohashi Cervical Cancer Questionnaire 令和7年度（2025年）子宮頸がん検診受診券

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　(YY)　(MM) Date of the end of treatment Name of disorder （　）
2	Have you received examination for cancer in the uterus in the past?	No	Yes	This is my　time　Date of previous examination　(YY) Results of previous exam: Normal • Follow-up exam needed　examination required abnormal findings Y/N
3	Do you have any blood relatives that had cancer? Uterine cancer	No	Yes	Who （　） type of cancer （ cervical cancer/endometrial cancer ）
	Other	No	Yes	Who （　） type of cancer （　）
4	Are you currently taking the following?	No	Yes	IUD • Birth Control Pill • Other hormonal contraceptives
5	Menstrual Cycle			Age of first period　years old　Age of menopause　years old Date of last period　(MM)　(DD) to　(DD) Regular • Irregular　Flow (Heavy • Medium • Light)
6	Have you ever had sexual intercourse?	Yes	No	

7	Are you currently pregnant?	No	Yes	How far along?　weeks
8	Pregnancy/ Childbirth			Pregnancy　times　Childbirth　times　Age at last child's birth　years old Natural childbirth　times　Caesarean section　times
9	Have you received the HPV vaccine (cervical cancer vaccine)?	No	Yes	First shot　(YY) Number of shots received　times
10	Symptoms Pain	No	Yes	Menstrual cramps • Abdominal pain • Back pain • Others
	Bleeding/ Discharge in last 6 months	No	Yes	Colour (Fresh blood • Light spotting • Brown spotting • Others) Flow (Heavy • Moderate • Light) When? Since　months ago (Once • Sometimes • Always) Does it occur after the following? (After intercourse • After bowel movements • During urination • Irregularly • Others)

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.

2025 Toyohashi Breast Cancer Questionnaire 令和7年度（2025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

1	Were you affected by any breast disorders or had surgery on your breasts?	No	Yes	Disorder • Surgery when I was　years old Name of disorder （ Right breast • Left breast ）
2	Have you undergone any breast cancer screening tests?	No	Yes	This is my　time　Date of previous examination　(YY) Type of test undergone　Ultrasound • Mammography Where did the screening test take place? （　） Results of previous exam: Normal • Follow-up exam needed　examination required abnormal findings Y/N (Right • Left)
3	Do you carry out breast self-exams?	No	Yes	Monthly • Sometimes
4	Have you had a gynecological disorder or surgery? (Uterus • Ovary)	No	Yes	Disorder • Surgery when I was　years old Name of disorder （　）
5	Have you undergone hormone therapy? (Menopause)	No	Yes	Treatment duration　months Name of disorder （　）
6	Have you undergone hormone therapy? (Menstrual irregularity)	No	Yes	Treatment duration　months Name of disorder （　）
7	Have you undergone radiation therapy?	No	Yes	Treatment duration　months Name of disorder （　）
8	Have you undergone for any of the following?	No	Yes	☐ Pacemaker implantation ☐ V-P(Ventriculoperitoneal shunting) ☐ Chest Port insertion ☐ Breast implants

9	Were you/Are you currently affected by cancer or any other illnesses?	No	Yes	years old Name of illness （　）
10	Menstrual Cycle			Age of first period　years old　Age of menopause　years old Date of last period　(MM)　(DD) - (DD)　Regular • Irregular
11	Pregnancy/Childbirth			Pregnancy　times　Currently Pregnant　months　After birth　months　Possibility of pregnancy (No • Yes) Childbirth　times　Age at first child's birth　years old Miscarriage　times　Age at last child's birth　years old
12	Were you/Are you currently nursing your child? **※You may not be permitted a mamograph if it has not been at least 6 month since you stopped breast feeding.**	No	Yes	☐ Currently nursing (Breast milk • Mixed) ☐ Have nursed in the past (Breast milk • Mixed) Have you nursed in the past 6 months? (No • Yes)
13	subjective symptoms			
	Pain	No	Yes	Right Left　From when? （　）
	Lumps	No	Yes	Right Left　From when? （　）
	Nipple changes	No	Yes	Right Left　From when? （　）
	Abnormal discharges	No	Yes	Right Left　From when? （　）
14	Are any of your family members affected by cancer? Breast	No	Yes	Relation （　）
	Others	No	Yes	Relation （　） Type of cancer （　）

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

1	Are you currently undergoing treatment for the following?		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 □ (YY) Previous numerical value □
3	Were you affected by the following?		No	Yes	Prostate gland enlargement ・ Inflammation of the prostate
4	Do you have any blood relatives that had cancer?	Prostate cancer	No	Yes	Grandfather/father/brothers
		Breast	No	Yes	Who （ ）
		Ovarian cancer	No	Yes	Grandmother/mother/sisters
5	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