④-a Personal Medical History (Symptoms diagnosed by a physician) Please black out in the box.

☐ **None**

A:Under treatment(taking medication) B:Currently visiting hospital(not taking medication)
C:Complete recovery(not visiting hospital)

Circulatory system･Brain disease

	A	B	C
Hypertension	☐	☐	☐
Arrhythmia	☐	☐	☐
Myocardinal angina pectoris	☐	☐	☐
Other heart diseases	☐	☐	☐
Name of disease ( )			
Cerebral infarction	☐	☐	☐
Cerebral hemorrhage	☐	☐	☐
Cerebral aneurysm	☐	☐	☐
Chest･abdominal aortic aneurysm	☐	☐	☐

Metabolism Endocrine disease

	A	B	C
Diabetes	☐	☐	☐
Dyslipidemia	☐	☐	☐
Hyperuricemia	☐	☐	☐
Disease of thyroid	☐	☐	☐

Hematologic disease

	A	B	C
Anemia	☐	☐	☐
Disease of red blood cells and white blood	☐	☐	☐
Name of disease ( )			

Liver disease

	A	B	C
Fatty liver	☐	☐	☐
Hepatitis B	☐	☐	☐
Hepatitis C	☐	☐	☐
Other liver diseases ( )			

Respiratory disease

	A	B	C
Asthma	☐	☐	☐
COPD･Emphysema	☐	☐	☐
pneumothorax	☐	☐	☐
Pulmonary tuberculosis	☐	☐	☐
Nontuberculous mycobacterial disease	☐	☐	☐
Interstitial pneumonia	☐	☐	☐
Other pulmonary diseases	☐	☐	☐
Name of disease ( )			

Digestive disease

	A	B	C
gastroesophageal reflux disease	☐	☐	☐
Stomach ulcer	☐	☐	☐
Chronic gastritis	☐	☐	☐
Duodenal ulcer	☐	☐	☐
Ulcerative colitis	☐	☐	☐
Diverticulitis of the colon	☐	☐	☐
hemorrhoid	☐	☐	☐
Gallstones	☐	☐	☐
Other digestive disorders	☐	☐	☐
Name of disease ( )			

Urological disease

	A	B	C
Chronic renal failure	☐	☐	☐
Chronic nephritis	☐	☐	☐
Prostatic hypertrophy	☐	☐	☐

Eye disease

	A	B	C
Glaucoma	☐	☐	☐
Cataracts	☐	☐	☐
Other ophthalmological diseases	☐	☐	☐
Name of disease ( )			

Gynecologic disease

	A	B	C
Uterine fibroid	☐	☐	☐
Ovarian cyst	☐	☐	☐
Other gynecologic disorders	☐	☐	☐
Name of disease ( )			

Cancer

	A	B	C
Breast cancer	☐	☐	☐
Lung cancer	☐	☐	☐
Esophageal cancer	☐	☐	☐
Stomach cancer	☐	☐	☐
colorectal cancer	☐	☐	☐
Prostate cancer	☐	☐	☐

Others

	A	B	C
Other diseases	☐	☐	☐
Name of disease ( )			

④-b If you are taking following medications, please black out in the box.

①Hypotensive ☐ **②antidiabetic drug** ☐ **③lipid lowering** ☐

⑤ Have you ever been underwent surgery? (Excluding external injuries such as fractures and wounds.)

No ☐ **Yes** ☐ Please indicate the details in the blank. ⇨ ( )

⑥ Do you have symptoms that consult medical attention?

No ☐ **Yes** ☐ ⇨ Please indicate the details in the blank. ( )

⑦ Review of Symptoms

If you have below symptoms within 3 months, please fill in the box.

☐ 01 **None**

☐ 47 Weight loss	☐ 41 Arrhythmia	☐ 11 Trouble swallowing	☐ 20 hematuria
☐ 07 Dizziness	☐ 04 Chest pain	☐ 14 Bloating	☐ 21 difficult to urinate
☐ 05 Palpitations at rest	☐ 08 Cough or phlegm	☐ 17 Constipation	☐ 44 Frequent urination(Night)
☐ 49 Palpitations during exertion	☐ 09 Blood-tinged sputum	☐ 19 Hematochezia	☐ 45 Frequent urination(a day)

⑧ For patients scheduled for stomach exam

Have you ever experienced allergies following an x-ray exam of your stomach? No ☐ Yes ☐ First time ☐

⑨ The following questions are for women only.

Please answer the following questions.

X-ray exams will not be performed if you answer "Yes" or "Not sure", so inform a staff member.

a. Are you on your period? No ☐ Yes ☐ Reached menopause ☐

b. Are you currently pregnant? No ☐ Yes ☐ Not sure ☐