

General health checkup questionnaire

※ Make sure that the writing is thick and accurate in the check box (□) with a black pen
(ex :)

!
Make sure to mark the inside of the check box.

Day of examination				[Barcode]
Name		Gender	<input type="checkbox"/> male <input type="checkbox"/> female	
Date of birth				
Phone No.				

[Medical history (disease history, family history)]

※ Please answer all the questions below.

1. Have you ever been diagnosed by a doctor with any of the following diseases or are you currently taking any medication?

	Diagnosis	Medication therapy		Diagnosis	Medication therapy
Brainstroke (paralysis)	<input type="checkbox"/>	<input type="checkbox"/>	Dyslipidemia	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac infarction /angina	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Others (including cancer)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			

2. Has anyone in your family died from or gotten any of the following diseases?

Brainstroke (paralysis)	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Cardiac infarction /angina	<input type="checkbox"/>	Others (including cancer)	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>		

3. Are you a Hepatitis B virus antigen carrier?

Yes No No idea

[Smoking and e – cigarettes (vaping)]

4. Have you ever smoked over 5 packs of tobacco (100 cigarettes) in your life?

- No, I never smoked. (⇐ Go to Question 5)
 Yes, I used to smoke but I stopped. (⇐ Go to Question 4-1)
 Yes, I'm still smoking (⇐ Go to Question 4-2)

4-1. If you used to smoke but stopped, please answer the following.
For how many years had you smoked?

	0	1	2	3	4	5	6	7	8	9
ten digit	0	1	2	3	4	5	6	7	8	9
units digit	0	1	2	3	4	5	6	7	8	9

Total _____ Years

How many cigarettes in a typical day did you smoke before you stopped?

	0	1	2	3	4	5	6	7	8	9
ten digit	0	1	2	3	4	5	6	7	8	9
units digit	0	1	2	3	4	5	6	7	8	9

Total _____ Cigarettes

4-2. If you are still smoking, please answer the following.
How long have you been smoking?

	0	1	2	3	4	5	6	7	8	9
ten digit	0	1	2	3	4	5	6	7	8	9
units digit	0	1	2	3	4	5	6	7	8	9

Total _____ Years

How many cigarettes on average do you smoke on a regular day?

	0	1	2	3	4	5	6	7	8	9
ten digit	0	1	2	3	4	5	6	7	8	9
units digit	0	1	2	3	4	5	6	7	8	9

Total _____ Cigarettes

5. Have you ever used an e-cigarette?

Yes (⇐ Go to Question 5-1) No

5-1. Have you used an e-cigarette in the last month?

No 1 to 2 days per month 3 to 9 days per month
 10 to 29 days per month Every day

[Drinking] ※ In the past one year

6. How often do you have drinks containing alcohol? (Select one)

- times per week times per month times per year
 I don't drink alcohol

_____ time	hundred	0	1	2	3	4	5	6	7	8	9
	tens	0	1	2	3	4	5	6	7	8	9
	ones	0	1	2	3	4	5	6	7	8	9

6-1. How many drinks containing alcohol do you have on a typical day when you are drinking?

- Soju Beer Hard liquor
 Makgeolli (Rice wine) Wine

Glass	Bottle	Can	cc
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

6-2. What is the largest amount of drinks containing alcohol that you have ever had in one day?

- Soju Beer Hard liquor
 Makgeolli (Rice wine) Wine

Glass	Bottle	Can	cc
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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[Exercising]

7-1. How often do you do high intensity exercise (making you short of breath) per week?

* Examples of high intensity exercise) Running, aerobics, fast bicycling, construction labor, carrying items using stairs, etc

0 day 1 day 2 days 3 days 4 days 5 days 6 days 7 days

7-2. How long do you do high intensity exercise (making you short of breath) per day?

_____ time	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11
	<input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23
_____ minute	<input type="checkbox"/> 0 <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 25 <input type="checkbox"/> 30 <input type="checkbox"/> 35 <input type="checkbox"/> 40 <input type="checkbox"/> 45 <input type="checkbox"/> 50 <input type="checkbox"/> 55

8-1. How often do you do moderate intensity exercise (making you slightly short of breath) per week?

0 day 1 day 2 days 3 days 4 days 5 days 6 days 7 days

8-2. How long do you do moderate intensity exercise (making you slightly short of breath) per day?

_____ time	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11
	<input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23
_____ minute	<input type="checkbox"/> 0 <input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 15 <input type="checkbox"/> 20 <input type="checkbox"/> 25 <input type="checkbox"/> 30 <input type="checkbox"/> 35 <input type="checkbox"/> 40 <input type="checkbox"/> 45 <input type="checkbox"/> 50 <input type="checkbox"/> 55

9. How many days did you do weight training such as push-ups, sit-ups, dumbbell exercises, weight lifting, or horizontal bar exercise in the last one week?

0 day 1 day 2 days 3 days 4 days 5 days 6 days 7 days

Additional health checkup questionnaires

Functional assessment of elderly ※ 66, 70, 80 years of age

1. Do you receive inoculations with influenza vaccine every year? Yes No
2. Have you received vaccinations against pneumonia? Yes No
3. The following questions are about your ability to perform activities of daily living. Please read and answer the questions below.

1) If someone sets the table for your meal, you can eat by yourself without any help.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Can you put on your clothes without any help?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Can you go to the toilet by yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) When you take a bath or a shower, can you wash by yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Can you prepare your meals?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Can you go to places that are of walking distance, such as a store, clinic, neighbor, or any public offices, by yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. About fall injury: Have you fell down during the last 6 months? Yes No

5. Urinary function: Do you have any difficulty in urinating or in holding your urine? Yes No

Mental Health (Depression) Assessment Tool

Patient Health Questionnaire-9: PHQ-9

The purpose of this questionnaire is to assess your level of depression. Although the questions are not for an exact diagnosis, it is very likely that you have depression if you receive high points. In such a case, we recommend that you see a psychiatrist for further evaluation.

※ 40, 50, 60, 70 years of age

How often have you suffered from the following symptoms over the past two weeks?	Not at all (0)	For a few days (1)	For over a week (2)	Almost every day (3)
1. I am barely interested in my work.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I feel melancholy, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. It is hard to fall asleep or I wake up very often during the night, or I sleep too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel exhausted or have no energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I have low appetite or eat too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I think that I am a bad person or a failure, or I feel like my family is unhappy because of me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I cannot concentrate when I read a newspaper or watch TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I move or talk too slowly to the point that other people can notice it, or I wander or pace around too much because I feel anxious and restless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I think I am better off dying, or I want to hurt myself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Points	/ 27			

National Cancer Screening Program

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These are questions about cancer

※ Please answer the following questions about your present condition by ticking the appropriate box

1. Do you have any **uncomfortable** areas in your body? Where?

Yes (symptom:) No

2. In the **last 6 months**, have you **experienced a weight decrease over 5 kg** without any specific reason?

No 5kg 6kg 7kg 8kg

weight loss → 9kg Over 10 kg ()

3. Do you have any family members, including yourself, who have cancer?

Type of cancer	No	No Idea	Yes (You may select multiple diseases)				
			You	Parents	Brother	Sister	Kids
Gastric Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon and Rectal Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Others()	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you ever undergone **these examinations** before?

Examination		Period			
		Over 10 years ago or none	Within 1 year	Between 1 and 2 years	Between 2 and 10 years
Gastric Cancer	Photography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon and Rectal Cancer	Fecal Occult Blood (Stool Test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Barium Enema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer	Cervical Skin Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatoma	Liver Ultrasound	None	Within 6 months	Between 6 and 12 months	Over more than 1 year
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These are questions only about gastric cancer, hepatoma, and colon and rectal cancer.

5. Have you ever been diagnosed with any **stomach disease**?

Disease	Yes	Disease	Yes	Disease	Yes
Gastric ulcer	<input type="checkbox"/>	atrophic gastritis	<input type="checkbox"/>	intestinal metaplasia	<input type="checkbox"/>
Polyp	<input type="checkbox"/>	others	<input type="checkbox"/>	None	<input type="checkbox"/>

6. Have you ever been diagnosed with any **colon disease**?

Disease	Yes	Disease	Yes	Disease	Yes
Polyp-rectal	<input type="checkbox"/>	Ulcerative colitis	<input type="checkbox"/>	Crohn's disease	<input type="checkbox"/>
Hemorrhoid	<input type="checkbox"/>	Other	<input type="checkbox"/>	None	<input type="checkbox"/>

7. Have you ever been diagnosed with any **liver disease**?

Disease	Yes	Disease	Yes	Disease	Yes
Hepatitis B carrier	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	Others	<input type="checkbox"/>	None	<input type="checkbox"/>

※ These are questions only about breast cancer and cervical cancer. (For women only.)

1. When was your first menstrual period? I have not gotten my period yet.

Start age	Age									
	0	1	2	3	4	5	6	7	8	9
ten digit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
units digit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you still experience menstrual periods?

Yes I have remove my cervix or uterus Menopause

Menopause	Age									
	0	1	2	3	4	5	6	7	8	9
ten digit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
units digit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Have you ever taken any medication or hormonal treatment to relieve any menopausal symptoms?

Never Yes; for less than 2 years Yes; for a period between 2 and 5 years
 Yes; for more than 5 years No idea

4. How many children do you have?

1 More than 2 No child

5. How long did you breast-feed your child?

Less than 6 months Between 6 and 12 months
 More than 1 year Not applicable

6. Have you been diagnosed with a **benign tumor**?

(Benign tumor is only a tumor, it is not a cancer and it is not even cancerous.)

Yes No No idea

7. Have you taken any **birth control pills**?

Never Less than 1 year Over 1 year
 No idea

Dental Health Screening Program

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(ex :)

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Make sure to mark the inside of the check box.

Day of examination		[Barcode]
Name	Gender <input type="checkbox"/> male <input type="checkbox"/> female	
Date of birth		
Phone No.		

[These are questions about your dental history and awareness about your oral health]

1. Have you visited a dental clinic during the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No idea
3. Do you have cardiovascular disease(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No idea
4. Do you have any difficulties in chewing food because of your teeth, gums, or dentures for the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you had a toothache or soreness for the last 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had any pain or bleeding in your gums?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. How do you describe your oral health, including your teeth and gums?	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good <input type="checkbox"/> Normal <input type="checkbox"/> Not well <input type="checkbox"/> Never been worse

[These are questions about your oral health habits (sugar intake, oral hygiene, use of fluoride, and smoking)]

9. Have you learned how to brush teeth from a dental clinic or health center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. How many times did you brush your teeth yesterday?	<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 times <input type="checkbox"/> 4 times <input type="checkbox"/> 5 times
11. How often did you brush your teeth before going to bed during the last week?	<input type="checkbox"/> Every day (7 times) <input type="checkbox"/> Almost every day (4~6 times) <input type="checkbox"/> Occasionally (1~3 times) <input type="checkbox"/> Never (0 times)
12. How often did you use dental floss or floss brush during the last week?	<input type="checkbox"/> Every day <input type="checkbox"/> Almost every day <input type="checkbox"/> Occasionally <input type="checkbox"/> Never <input type="checkbox"/> I do not know what a dental floss or floss brush is.
13. Does your toothpaste contain fluoride?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I do not know
14. How many times do you consume sweets or sticky snacks, such as cookies, candies, and cakes, per day?	<input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> 2~3 times <input type="checkbox"/> More than 4 times <input type="checkbox"/> I do not know
15. How many times do you drink soda or sweet drinks (including sports drink, ion supply drinks, and fruit juices)?	<input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> 2~3 times <input type="checkbox"/> More than 4 times <input type="checkbox"/> I do not know
16. Do you smoke?	<input type="checkbox"/> Never smoked <input type="checkbox"/> Currently smoke <input type="checkbox"/> Smoked in the past but stopped

※ Please write any question(s) to ask or describe if you have a special condition that needs a doctor's attention.