

# HIF Medical Report

Due by May 8, 2013

To be completed by an examining physician (MD or Certificated Nurse Practitioner/Physician's Assistant only)  
ONLY after a recent medical examination. No other forms will be accepted in substitution of this form.

Patient's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_

Date of Examination \_\_\_\_\_ How long have you known the patient? \_\_\_\_\_

Please comment on the patient's medical history by answering the following questions with Yes, No, or Not Applicable.

### Has the patient:

- |  |   |                               |   |
|--|---|-------------------------------|---|
| had any past surgeries?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | ever been hospitalized?       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| had asthma?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | had an anaphylactic reaction? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| had psychological<br>or psychiatric treatment? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |                               |   |

A: If you checked yes, to any of the above, please attach a sheet providing details including date, medication(s), and indication(s) regarding applicable ones. Detailed information is much appreciated so that HIF can provide the accurate information to doctors in Japan in case of necessity.

B: Are there any conditions that might still affect this patient?  Yes  No  
If yes, please provide comments on a separate sheet of paper.

### Please mark all conditions that CURRENTLY affect this patient:

- |   |   |
|---|---|
| <input type="checkbox"/> Allergies of any kind              | <input type="checkbox"/> Jaundice/hepatitis                       |
| <input type="checkbox"/> Cancer or tumors                   | <input type="checkbox"/> Liver or gall bladder problems           |
| <input type="checkbox"/> Chronic respiratory problems       | <input type="checkbox"/> Menstrual problems                       |
| <input type="checkbox"/> Chronic digestive/GI problems      | <input type="checkbox"/> Narcotic/alcohol dependency              |
| <input type="checkbox"/> Colitis                            | <input type="checkbox"/> Psychological/psychiatric conditions     |
| <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Reaction to antibiotics                  |
| <input type="checkbox"/> Dizziness/fainting spells          | <input type="checkbox"/> Recent gain of weight                    |
| <input type="checkbox"/> Eating Disorder                    | <input type="checkbox"/> Recent loss of weight                    |
| <input type="checkbox"/> Epilepsy or seizures               | <input type="checkbox"/> Skin diseases                            |
| <input type="checkbox"/> Frequent indigestion or ulcer      | <input type="checkbox"/> Thyroid problem                          |
| <input type="checkbox"/> Heart or circulatory complications | <input type="checkbox"/> Trouble with eyes, ears, nose, or throat |
| <input type="checkbox"/> Head inquiry                       | <input type="checkbox"/> Tuberculosis                             |
| <input type="checkbox"/> High blood pressure                | <input type="checkbox"/> Venereal disease                         |
| <input type="checkbox"/> Other _____                        |   |

C: If you checked any of the above, please attach a letter explaining detailed symptoms, medication(s), dosage(s) and use(s). You may also add information about any advice you've given the patient in respect of any of the above conditions. This will be useful for the consulting physician in Japan.

Please check one of the following paragraphs, and write your signature below.

- To the best of my knowledge, the above named patient has no physical or psychological conditions that would prevent him/her from participating successfully in an eight-week study program in Japan.
- I do not recommend that this applicant participate in an eight-week study program in Japan due to present health conditions.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (please print) \_\_\_\_\_

Physician's Address \_\_\_\_\_

Physician's Tel, and e-mail address \_\_\_\_\_

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