

## National Screening Program

**Regular checkup**

**Life cycle-based checkup**

※ Answers must be provided for all questions so the information will be reported correctly.

First Name		Residential ID No.		Telephone	Home	
Given Name					Mobile phone	
Current address					Zip code	-
					E-mail	

※ These are questions about your medical history.

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

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

Disease	Brain stroke / paralysis	Heart disease (cardiac infarction / angina)	High blood pressure	Diabetes	Dyslipidemia	Tuberculosis	Others (including cancer)
a							
b							

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

Disease	Brain stroke / paralysis	Heart disease (cardiac infarction / angina)	High blood pressure	Diabetes	Others (including cancer)
Yes					

3. Are you a **Hepatitis B virus antigen carrier**?      ① Yes      ② No      ③ No idea

※ These are questions about smoking.

4. Please answer the following questions **about your present condition** by ticking the appropriate box.

4-1. Have you ever smoked over 5 packs of tobacco (100 cigarettes) in your life?

- ① No, I never smoked. (☞ Go to Question 5)      ② Yes, I used to smoke but I stopped. (☞ Go to Question 4-2)  
 ③ Yes, I'm still smoking (☞ Go to Question 4-3)

4-2. If you **used to smoke** but stopped, please answer the following.

For how many years had you smoked?	Total _____ years
How many cigarettes in a typical day did you smoke before you stopped?	_____ cigarettes

4-3. If you **are still smoking**, please answer the following.

How long have you been smoking?	Total _____ years
How many cigarettes on average do you smoke on a regular day?	_____ cigarettes

※ These are questions about drinking.

5. Please answer the following questions about your current drinking habit by ticking the appropriate box.

5-1. **How many times a week** do you drink alcohol?

- 0     1     2     3     4     5     6     7

5-2. When you drink, **how much do you usually** drink on a regular day? ( \_\_\_\_\_ glass(es))

(※ No matter what kind of liquor it may be, each glass will be considered as 1 glass. However, 1 can of beer (355 cc) is equal to 1.6 glasses of beer.)

※ These are questions about exercising.

6. These are questions about **your physical activity for the last week**. Please answer the following questions by ticking the appropriate box.

6-1. During the last week, how many days did you exercise vigorously for over 20 minutes until you were almost out of breath? (example: running, aerobics, high-speed cycling, mountain hiking, etc.)

- 0    1    2    3    4    5    6    7

6-2. During the last week, how many days did you exercise in a moderate level for more than 30 minutes until you had to breathe a little faster than usual? (example: fast walking, tennis, bicycle riding, cleaning, etc.) ※ Except the relevant answer from 6-1

- 0    1    2    3    4    5    6    7

6-3. During the last week, how many days did you walk for a total of 30 minutes or more in a day, including separate 10-minute walks? (example: light exercise, walk for work or for leisure, etc.)

※ Please exclude exercises you answered in 6-1 and 6-2

- 0    1    2    3    4    5    6    7

※ These are questions about cognitive functions. (Only answer if you are 66, 70, or 74 years old.)  
(If a family member accompanied you, please let him/her answer the questions. If not, answer the following questions by yourself.)

7. Please answer the following questions about **your current cognitive condition compared to last year** by ticking the appropriate box.

7-1. Compared to friends or other people, your memory is worse than others.

- ① No   ② Occasionally   ③ Yes

7-2. Your memory is worse compared to last year.

- ① No   ② Occasionally   ③ Yes

7-3. You experience problems related to your memory when handling important matters.

- ① No   ② Occasionally   ③ Yes

7-4. Has anyone noticed that you have a short memory?

- ① No   ② Occasionally   ③ Yes

7-5. Do you experience difficulties in performing daily chores that you used to do well before?

- ① No   ② Occasionally   ③ Yes

※ Emotional status (Only answer if you are 40 years old.)

8. Please identify how many times you experienced the following **during the last week** by ticking the appropriate box.

<b>During the last week, I</b>	Hardly ever (less than 1 day)	Not too often (couple of days)	Sometimes (more than 3 days)	Always (over 5 days)
8-1. Was annoyed and bothered by things that were not there before.				
8-2. Did not want to eat and even lost appetite.				
8-3. Felt sad even when someone tried to help me out.				
8-4. Felt depressed.				

※ Please complete this form with Annex No. 2 only 66 years old.



※ **These are questions about affective status.**

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

3-1. Have you become less active and have little will to do anything lately?

① Yes

② No

3-2. Do you feel you are useless?

① Yes

② No

3-3. Do you feel that your future is hopeless?

① Yes

② No

※ **These are questions about fall injury and urinary function.**

4. About **fall injury**: Have you fell down during the last 6 months?

① Yes

② No

5. **Urinary function**: Do you have any difficulty in urinating or in holding your urine?

① Yes

② No



## National Cancer Screening Program

**Regular checkup**

**Life cycle-based checkup**

Fist Name		Residential ID No.		Telephone	Home	
Given Name		ID No.			Mobile phone	
<input type="checkbox"/> Health insurance <input type="checkbox"/> Medicaid recipient			E-mail			
Current address						Zip code
						-

**※ 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?

① Yes (symptom: \_\_\_\_\_)      ② No

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

① No      ② Yes; total weight loss (          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							
Breast Cancer							
Colon and Rectal Cancer							
Hepatoma							
Cervical Cancer							
Others (          )							

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
<b>Gastric Cancer</b>	Photography				
	Endoscopy				
<b>Breast Cancer</b>	Mammogram				
<b>Colon and Rectal Cancer</b>	Fecal Occult Blood (Stool Test)				
	Barium Enema				
	Endoscopy				
<b>Cervical Cancer</b>	Cervical Skin Exam				
<b>Hepatoma</b>	Liver Ultrasound	None	Within 6 months	Between 6 and 12 months	Over more than 1 year

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

※ Please mark 'O' that **corresponds to your condition.**

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

Disease	Gastric ulcer	Gastritis	Duodenal ulcer	Polyp	Others (write)	None
Yes						

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

Disease	Polyp—rectal	Ulcerative colitis	Crohn's disease	Hemorrhoid	Others (write)	None
Yes						

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

Disease	Hepatitis B carrier	Hepatitis B	Hepatitis C	Cirrhosis	Others (write)	None
Yes						

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

8. When was your first menstrual period?

- ① Age \_\_\_\_\_                      ② I have not gotten my period yet.

9. Do you still experience menstrual periods?

- ① Yes                                      ② I have remove my cervix or uterus  
 ③ Menopause (age: \_\_\_\_\_)

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

- ① Never                                      ② Yes; for less than 2 years  
 ③ Yes; for a period between 2 and 5 years                      ④ Yes; for more than 5 years                      ⑤ No idea

11. How many children do you have?

- ① 1    ② More than 2    ③ No child

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

- ① Less than 6 months    ② Between 6 and 12 months    ③ More than 1 year    ④ Not applicable

13. 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.**)

- ① Yes    ② No    ③ No idea

14. Have you taken any birth control pills?

- ① Never    ② Less than 1 year  
 ③ Over 1 year    ④ No idea





## Health risk evaluation result

### Specific health risk for each disease

### Knowing your health risk factors

### Controlling your health risk factors

※ A health risk evaluation is carried out to induce improved behavior toward health from subjects to reduce health risks by predicting possible diseases they may have and their future health status through the analysis of the subjects' health risk factors based on the questionnaire completed by the subjects and their checkup result.

**We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above**

Determination date                      Examined doctor      License (Qualification) number                      Name                      (signature)  
(Medical institution number                      )

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.

## Results of Regular Medical Checkup (2<sup>nd</sup>)

Subject name	Resident registration number	-	Health checkup institution	<input type="checkbox"/> Visit, <input type="checkbox"/> on-site checkup	examination
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### How is the general impression of my checkup result??

● Mr./Mrs./Ms. \_\_\_\_\_, you need to take **immediate actions** for the following details.

● Mr./Mrs./Ms. \_\_\_\_\_, you need to have **great focus to manage** the following details.

### How is my health checkup result?

<b>Diabetes mellitus</b>	Fasting blood sugar	<input type="checkbox"/> Normal	<input type="checkbox"/> Fasting blood sugar disorder	<input type="checkbox"/> Diabetes mellitus
	_____mg/dl	( )	( )	( )
<b>Hypertension</b>	Systolic	<input type="checkbox"/> Normal	<input type="checkbox"/> Pre-stage of hypertension	<input type="checkbox"/> Hypertension
	_____mmHg	a systolic level of less than 120 and a diastolic level of less than 80	a systolic level of 120-139 or a diastolic level of 80-89	A systolic level greater than 140 or a diastolic level greater than 90
	Diastolic	_____mmHg		
<b>Cognitive function disorder (70 and 74 years old)</b>	_____points	<input type="checkbox"/> No specific abnormality (0-5 points)	<input type="checkbox"/> Declined cognitive function (6-30 points; additional examination and consultation required)	

We notify your general health checkup result (second examination) as above.

Determination date      Examined doctor      License (Qualification) number      Name      (signature)

(Medical institution number \_\_\_\_\_)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.



**Chronic illness and improvement of lifestyle**

“Disease information related to the objective disease”





## Health risk evaluation result

### Specific health risk for each disease

### Knowing your health risk factors

### Controlling your health risk factors

## Result for lifestyle evaluation


We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above

Determination date                      Examined doctor      License (Qualification) number                      Name (signature)  
(Medical institution number                      )

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..



## How is the result of my major health status?

\*  Figures written in the boxes are your the result values of your health checkup..

\* Blood test result may vary according to the reference criteria used by each health checkup institution in the determination of normal A, normal B, and suspected disease.

Test type	Objective disease	Examination item	Examination result			
Measuring examination	Obesity	Height/weight (cm/kg)	/			
		Waist (cm)	Normal A		Disease suspected	
		Male 90, Female 85				
	Hypertension	BMI (kg/m <sup>2</sup> )	Normal B	Normal A	Normal B	Disease suspected
			18.5	25	30	
	Abnormality of visual acuity, auditory acuity	Systolic blood pressure (mmHg)	Normal A	Normal B	Disease suspected	
120			140			
Abnormality of visual acuity, auditory acuity	Diastolic blood pressure (mmHg)	Normal A	Normal B	Disease suspected		
		80		90		
	Visual acuity (left/right)	/	<input type="checkbox"/> corrected	Auditory acuity (left/right)	/	

Blood test	Anemia	Hemoglobin (g/dL)	Normal A	Normal B	Disease suspected	
		( )	( )	( )		
	Diabetes Mellitus	Fasting blood sugar	Normal A	Normal B	Disease suspected	
		( )	( )			
	Dyslipidemia	Total cholesterol (mg/dL)	Normal A	Normal B	Disease suspected	
			( )	( )		
			HDL cholesterol (mg/dL)	Normal A	Normal B	Disease suspected
				( )	( )	
	Triglyceride (mg/dL)	Normal A	Normal B	Disease suspected		
		( )	( )			
LDL cholesterol (mg/dL)	Normal A	Normal B	Disease suspected			
	( )	( )				
Kidney disease	Serum creatinine (mg/dL)	Normal A	Disease suspected			
		( )				
Liver disease	Glomerular filtration rate (e-GFR) (mL/min/1.73 m <sup>2</sup> )	Normal A	Disease suspected			
		( )				
		AST(SGOT)(U/L)	Normal A	Normal B	Disease suspected	
			( )	( )		
ALT(SGPT)(U/L)	Normal A	Normal B	Disease suspected			
	( )	( )				
Gamma-GTP (γ-GTP)(U/L)	Normal A	Normal B	Disease suspected			
	( )	( )				

Urinalysis	Kidney disease	Proteinuria
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Image	Pulmonary tuberculosis / thoracic disease	Chest X-ray
	Osteoporosis	Bone density test

Geriatric physical function test	Fall	Lower extremity function
		Balance

Physical examination (questionnaire)	Past medical history diagnosis	Medication therapy	
	Lifestyle	Trauma and sequela	General status
	General status	Depression test	

## Health risk evaluation result

### Specific health risk for each disease

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### Knowing your health risk factors

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### Controlling your health risk factors

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### Results for disease prevention and evaluation of performance ability for daily life activities

### Result for evaluation of geriatric physical function

<ul style="list-style-type: none"> <li>● Flu vaccination <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>● Risk for falling (Whether to experience falling) <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>● Dysuria suspected <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>● Risk for osteoporosis (Female) <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>● Performance ability for everyday activities <input type="checkbox"/> Normal <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</li> </ul>	<ul style="list-style-type: none"> <li>● Visual acuity <input type="checkbox"/> Normal <input type="checkbox"/> Loss of eyesight</li> <li>● Auditory acuity <input type="checkbox"/> Normal <input type="checkbox"/> Loss of hearing</li> <li>● Function test <input type="checkbox"/> Normal <input type="checkbox"/> Mild <input type="checkbox"/> Severe</li> </ul>
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### Result for lifestyle evaluation

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※ You can receive specific details from a physician about the results of this 2nd test.

**We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above**

Determination date	Examined doctor	License (Qualification) number	Name	(signature)
			(Medical institution number	)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..

## Results of 2nd Life Cycle-based Medical Checkup

Subject name	Resident registration number	-	Health checkup institution	<input type="checkbox"/> Visit, <input type="checkbox"/> on-site checkup	examination
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### How is the general impression of my checkup result?

- Mr./Mrs./Ms. \_\_\_\_\_, you need to take **immediate actions** for the following details.
  
- Mr./Mrs./Ms. \_\_\_\_\_, you need to have **great focus to manage** the following details.

### Summary of my 1st health checkup results

### How is my health checkup result?

<b>Diabetes mellitus</b>	Fasting blood sugar _____mg/dl	<input type="checkbox"/> Normal ( )	<input type="checkbox"/> Fasting blood sugar disorder ( )	<input type="checkbox"/> Diabetes mellitus ( )
	Systolic _____mmHg	<input type="checkbox"/> Normal	<input type="checkbox"/> Pre-stage of hypertension	<input type="checkbox"/> Hypertension
<b>Hypertension</b>	Diastolic _____mmHg	a systolic level of less than 120 and a diastolic level of less than 80	a systolic level of 120-139 or a diastolic level of 80-89	A systolic level greater than 140 or a diastolic level greater than 90
	<b>Cognitive function disorder (66 years old)</b>	_____points	<input type="checkbox"/> No specific abnormality (0-5 points)	<input type="checkbox"/> Declined cognitive function (6-30 points; additional examination and consultation required)
<b>Depression (40 years old)</b>	_____points	<input type="checkbox"/> No specific abnormality (0-20 points)	<input type="checkbox"/> Borderline (21-24 points)	
		<input type="checkbox"/> Depression suspected (25-60 points; additional examination and consultation required)		
<b>Depression (66 years old)</b>	_____points	<input type="checkbox"/> No specific abnormality (0-9 points)	<input type="checkbox"/> Borderline (10-11 points)	
		<input type="checkbox"/> Depression suspected (12-15 points; additional examination and consultation required)		

## How is the result of my lifestyle evaluation?



**Evaluation  
Prescription**

- Low (0-3 points)       Middle (4-6 points)       High (7-10 points)
- Consultation and education       Nicotine replacement therapy (gum, patch, candy, etc.)
- Referral (to a smoking cessation clinic or hotline)

points



**Evaluation  
Prescription**

- Proper alcohol assumption       Dangerous alcohol consumption       High-risk alcohol consumption (Alcohol overuse, alcohol dependency)
- Consultation and education       Medication therapy       Referral (to Alcohol Anonymous, alcohol cessation clinic)

points



**Evaluation  
Prescription**

- Insufficient       Normal       Sufficient
- Type :  Power walking       Swimming       Mountain climbing       Aerobics       Stretching
- Muscular exercise       Others ( )       Referral
- Time :  10 minutes       15-30 minutes       Over 30 minutes       Others
- Frequency:  1-2 times a week       3-4 times a week       More than 5 times a week

points



**Evaluation  
Prescription**

- Bad       Normal       Good
- Please increase food intake. ( Dairy       Proteins       Vegetables and fruits)
- Please decrease ( Fat       Simple sugar       Salinity (Salt))
- Healthy eating habits ( Not skipping breakfast       Eating a balanced variety of foods)
- Referral (Nutrition education class)

points



**Evaluation  
Prescription**

- Body mass index:  Low weight       Normal weight       Severe obesity      Waist measurement:  Abdominal obesity
- Please decrease the amount of food intake.       Please decrease daytime and nighttime snacks.
- Please decrease the amount and frequency of alcohol consumption.       Please decrease dining out and fast food intake.
- Please refer to the exercise prescription.       Referral (Obesity clinic)
- Others ( )

We hereby notify you of the health checkup (second examination) result for the lifetime transition period as above

Determination date

Examined doctor

License (Qualification) number

Name

(signature)

(Medical institution number )

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..

**Chronic illness and improvement of lifestyle**

“Disease information related to the objective disease”

## Results of Dental Health Screening

Regular checkup  Life cycle-based checkup

Name of Examinee	Resident registration number	Health checkup institution <input type="checkbox"/> visit, <input type="checkbox"/> on-site checkup	examination
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### How is the result of my oral checkup?

**Determination -**  Normal A  Normal B  Caution  Treatment required

● Mr./Mrs./Ms. , you need to take **immediate actions** for the following details.

● Mr./Mrs./Ms. , you need to have **great focus to manage** the following details.

### How is the result of my oral examination?

 Evaluation of questionnaire	(Dental department) Medical history issue	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Oral health awareness issue	<input type="checkbox"/> No	<input type="checkbox"/> Yes
	Oral health habit issue	Oral hygiene: <input type="checkbox"/> No <input type="checkbox"/> Yes	Fluoride use : <input type="checkbox"/> No <input type="checkbox"/> Yes
		Sugar intake: <input type="checkbox"/> No <input type="checkbox"/> Yes	Smoking : <input type="checkbox"/> No <input type="checkbox"/> Yes

<b>Dental examination</b>	Decayed tooth :	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<b>Periodontal biopsy</b>	<input type="checkbox"/> No	<input type="checkbox"/> Mild	<input type="checkbox"/> Severe
	Tooth with interproximal caries suspected :	<input type="checkbox"/> No	<input type="checkbox"/> Yes		<b>Periodontal disease</b>	<input type="checkbox"/> No	<input type="checkbox"/> Mild
<b>Dental caries (cavity)</b>	Repaired tooth :	<input type="checkbox"/> No	<input type="checkbox"/> Yes				
	Lost tooth :	<input type="checkbox"/> No	<input type="checkbox"/> Yes				

<b>Dental examination</b>	
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<b>Result Note</b>	▶ Prevalence of dental caries for permanent tooth (Year of 2010 / %)  (Ministry of Health and Welfare. 2010 National oral health survey. 2011)	<table border="1"> <thead> <tr> <th></th> <th>Subjects</th> <th>Male</th> <th>Female</th> </tr> </thead> <tbody> <tr> <td>19~29 years old</td> <td>39</td> <td>42</td> <td>35</td> </tr> <tr> <td>30~39 years old</td> <td>38</td> <td>42</td> <td>34</td> </tr> <tr> <td>40~49 years old</td> <td>34</td> <td>37</td> <td>31</td> </tr> <tr> <td>50~59 years old</td> <td>29</td> <td>31</td> <td>23</td> </tr> <tr> <td>60~69 years old</td> <td>28</td> <td>33</td> <td>23</td> </tr> <tr> <td>Over 70 years old</td> <td>27</td> <td>31</td> <td>25</td> </tr> </tbody> </table>		Subjects	Male	Female	19~29 years old	39	42	35	30~39 years old	38	42	34	40~49 years old	34	37	31	50~59 years old	29	31	23	60~69 years old	28	33	23	Over 70 years old	27	31	25	▶ Description for examinations - Decayed tooth: Tooth with dental caries - Tooth of interproximal caries suspected Teeth of suspected dental caries taking place between teeth - Repaired tooth: Tooth treated or repaired from dental caries by crowning gold, resin, or amalgam - Lost tooth: Loosened tooth required to be replaced because of dental caries - Gingivitis: Extent to which gums with inflammation
			Subjects	Male	Female																										
19~29 years old	39	42	35																												
30~39 years old	38	42	34																												
40~49 years old	34	37	31																												
50~59 years old	29	31	23																												
60~69 years old	28	33	23																												
Over 70 years old	27	31	25																												

※ The following examinations are only applicable to health checkup for lifetime transition period for people "40 years old."

<b>Dental plaque examination</b>	Dental plaque of the first upper right molar (No. 16)	:	points	<b>Determination</b>
	Dental plaque of the upper right central incisor (No. 11)	:	points	
	Dental plaque of the first upper left molar (No. 26)	:	points	
	Dental plaque of the first lower left molar (No. 36)	:	points	
	Dental plaque of the lower central left incisor (No. 31)	:	points	
	Dental plaque of the first lower molar of the right (No. 46)	:	points	
<b>Average</b>			<b>points</b>	- Good (Less than 1 point) - Normal (Less than 1~3 points) - Bad (More than 3 points)
				※ <b>Average point</b> = sum of the points of every dental surface / the number of evaluated teeth

We notify the result of your oral checkup as above.

Determination date                      Dentist:                      License (Qualification) number                      Name                      (signature)

(Office code                      )

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.

## Results of Stomach Cancer Screening

Full Name		Residential ID No.	- 1(2)*****
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Classification	Test list (date of examination)		Results	Decision ※ Write it below following the examination rule
Stomach Cancer	Name of Test — date/year	Opinion (location)  ※ Write cancer location following the opinion.		
	※ Maximum 2 tests (Upper gastrointesttinography, Endoscopy)	Pathology  ※ In case Tissue Test was not taken, leave this blank.		
	Recommendation			
	Date of results	Date/Year	Examining physician	License No.  Name of doctor

## Results of Stomach Cancer Screening

- ※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.
- ※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.
- ※ Stomach cancer has the highest incidence rate compared to all cancers in South Korea. It is possible to detect it through regular medical checkups and when detected early, it is commonly overcome through endoscopy remedy or surgery.
- ※ We recommend persons of both sexes who are over 40 to receive endoscopy or upper gastrointesttinography every 2 years even if they do not experience any symptoms because the possibility of stomach cancer sharply increases after age 40.
- ※ If you experience symptoms, such as stomachache, heartburn, among others, please consult with a physician even though "no abnormality" was found from the stomach cancer examination. If your test result is not "no abnormality", please follow the physician's instructions.

**We are notifying you of these medical examination results as follows.**

Office code

Office name

Date/Year

※ The cancer exam form follows the examination rule on extra cancer exam reports.

## Results of Liver Cancer Screening

Full Name		ID No.	- 1(2)*****
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Classification	Test list (date of examination)	Results	Decision <small>※ Write it below following the examination rule.</small>	
Liver Cancer	Name of examination — date/year  <small>※ Maximum of 5 tests, including 2 or 3 tests for liver disease, ultrasonography, or Alpha-fetoprotein test.</small>			
	Recommendation			
	Date of results	Date/Year	Examining physician	License No.
			Name of doctor	(signature)

<b>Results of Liver Cancer Screening</b>	
<p>※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.</p> <p>※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.</p> <p>※ For liver cancer screening, it is recommended for high-risk group members who are over 40 years old (patients with cirrhosis, hepatitis B antigen-positive patients, hepatitis C antibody-positive patients, and patients with chronic liver disorder caused by hepatitis B or C viruses) to receive regular screening (liver ultrasound and serum alpha-fetoprotein examination) every 6 months.</p> <p>※ Not all cancers are diagnosed by this liver cancer screening. If you experience suspicious symptoms (such as loss of weight, jaundice, sudden fatigue, among others), please consult with a physician. If your test result is not "no abnormality", please follow the physician's instructions.</p> <p style="text-align: center; margin-top: 20px;"><b>We are notifying you of these medical examination results as follows.</b></p> <div style="text-align: right; margin-top: 20px;">Date/Year</div> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <span>Office code</span> <span>Office name</span> </div>	

※ The cancer exam form follows the examination rule on extra cancer exam reports.

## Results of Colon Cancer Screening

Full Name		ID No.	- 1(2)*****
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Classification	Test list (date of examination)		Results	Decision <small>※ Write it below following the examination rule.</small>	
Colon Cancer	Name of test — date/year	Opinion (location)			
	※ Maximum of 3 tests including fecal occult blood test (FOBT), digital rectal exam (DRE), or endoscopy	※ Record recommendations based on FOBT (no location of lesion). ※ The opinion regarding only FOBT does not need to be written down			
		Pathology			
		※ In case there is no pathology exam, leave this blank.			
Recommendation					
	Date of result	Date/Year	Examining physician	License No.	
				Name of doctor	(signature)

### The Result of Colon Cancer Screening

- ※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.
- ※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.
- ※ The incidence rate of colon cancer has recently been on the rise. With this, it is possible to detect it through regular medical checkups and when found early, it is commonly overcome through endoscopy remedy or surgery.
- ※ Because of the sharp rise in the incidence of colon cancers on those over age 50, we recommend both men and women over 50 to have an annual fecal occult blood test screening even when there are no signs or symptoms. When the results of the fecal occult blood test come out abnormal, the presence of colon cancer can be confirmed by DRE or colonoscopy.
- ※ Not all colorectal diseases are diagnosed by fecal occult blood test. If you experience any suspicious symptoms (such as loss of weight, changes in thickness of stool, bloody stool, among others), please consult with a physician even though the result of the stool guaiac test is negative. If your test result is not "no abnormality", please follow the physician's instructions.

**We are notifying you of these medical examination results as follows.**

Office code

Office name

Date/year

※ The cancer exam form follows the examination rule on extra cancer exam reports.

## Results of Breast Cancer Screening

Classification	The examination list (date of examination)		Results	Decision ※ Write it below following the examination rule.	
Breast Cancer	X-ray mammography (date/year)	Opinion (location)  ※ Write the cancer location following the opinion.			
	Recommendation				
	Date of results	Date/Year	<b>Examining physician</b>	License No.	
			Name of doctor	(signature)	

Full Name		ID No.	- 1(2)*****
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### The Result of Breast Cancer Screening

※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ The incidence rate of breast cancer has recently been on the rise. With this, it is possible to detect early and/or cure the said cancer through regular health checkups.

※ We recommend that persons over 40 receive breast X-ray every 2 years for early disease detection.

※ Even though no abnormality was found from the breast cancer screening test, a person that has undergone breast surgery in the past and has a lump around her breast must consult with a physician. If your test result is not "no abnormality", please follow the physician's instructions.

**We are notifying you of these medical examination results as follows.**

Date/year

Office code
Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

## Results of Cervical Cancer Screening

Full Name		ID No.	- 1(2)*****
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Classification	Test list (date of examination)		Results	Decision <small>※ Write it below following the examination rule</small>	
Cervical Cancer	Pap smear screening (date/year)	Pathological types (biopsy procedures) <small>※ If you did not perform this exam, leave this blank.</small>			
	Recommendation				
	Date of results	Date/Year	<b>Examining physician</b>	License No.	(signature)
			Name of doctor		

### Results of Cervical Cancer Screening

- ※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.
- ※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.
- ※ It is possible to detect cervical cancer early through a biopsy screen test. In case of early detection, cervical cancer is commonly overcome with a simple surgery.
- ※ We recommend that women who are over 20 years old and already have sexual experience receive a Pap smear every 2 years.
- ※ If you experience symptoms, such as abnormal cervical bleeding, among others, please consult with a physician even though no abnormality was found from the cervical cancer screening test. If your test result is not "no abnormality", please follow the physician's instructions.

**We are notifying you of these medical examination results as follows.**

Date/year

Office code

Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

## Consent to the utilization of health checkup result for follow-up management

\* Please check examinations to which you agree to provision of information.

- [  General health checkup(including health checkup for the lifetime transition period ),  Cancer screening  
 Health checkup for infants ]

This form is used to obtain your informed consent on:

Your or your child's health checkup result or health management history from the National Health Insurance Service at a public health center so that **proper health management service\*** can be provided. (\*for subjects who have diseases or are suspected of having hypertension, diabetes, dyslipidemia, declined cognitive function, etc., in their general health checkups and lifetime health checkups, and for parents who need comprehensive evaluation and consistent management after receiving the health checkup results of their infants or children)

The cancer screening result from the National Health Insurance Service at the National Cancer Center or a public health center so that post-management can be provided to subjects who have abnormal findings or are suspected of having, or had been diagnosed with, cancer.

\* Health management service: Health consultation, education, smoking cessation, alcohol abstaining, exercise, nutrition, dementia examination, supporting the cost for in-depth examination for developmental disorder of infants, etc.

※ Your personal information will be utilized in the extent of obligation of confidentiality in accordance with the Personal Information Protection Act and the Framework Act of Health Examinations and will not be provided to other institutions for other purposes other than the original usage.

※ If you would like to withdraw your consent, it can be withdrawn through a simple verification procedure as you call to the National Health Insurance Corporation customer service (1577-1000) or its district branch.

### 1. Agreement for provision of personal information

I have been sufficiently informed of the terms below in which my personal information will be provided to the public health center and the National Health Insurance Corporation and consent to provide related details that I have been notified of.

① Institutions providing information: public health center, [National Cancer Center](#), and National Health Insurance Service

② Purposes of providing personal information: To provide healthcare services to those who require self-management and preventive measures and those who have a disease (and suspected of having a disease), and to provide [post-management based on the cancer screening result](#)

③ Personal information willing to provide

- Corporation → Public health center

• Personally identifiable information, such as name, resident registration number, address, telephone number, e-mail, etc., and health checkup result and treatment via texting

- Public health center → Corporation : Name, resident registration number, health service management details that you have been offered

- [National Health Insurance Service](#) → [National Cancer Center and public health center](#)  
[Personal identification information such as name, resident registration number, telephone number, e-mail address, and cancer screening results and questionnaire data](#)

④ Period of retaining and utilizing personal information: 2 years

⑤ You have the right to refuse to agree to provide personal information to the third party, and in this case, you might be excluded as a subject who is offered with health management service of a public health center.

I consent to the terms.  Disagree

### 2. Sensitive information

I was notified by the health checkup institution on personal information processing, and with this, they sufficiently explained that my health checkup information and health management service history of the public health center are sensitive information. Therefore, I fully understand and consent to the terms.

I consent to the terms.  Disagree

### 3. Consent to the process of identification information

I was notified by the health checkup institution on personal information processing, and with this, they sufficiently explained that the resident registration number is an identification number. Therefore, I fully understand and consent to the terms.

I consent to the terms.  Disagree

**I consent to the entire contents.**

Year      Month      Day

Conse nter	Subject name	(signature)	Resident registration number	
	(In case of infants) Name of legal representative	(signature)	Relationship to the subject	
Name of health checkup institution (Number)				

## Evaluation of Cognitive Function Difficulty for Those Aged 66, 70, 74

**This questionnaire is for cognitive function difficulty. Please answer the following questions about your present condition compared to last year by ticking the appropriate box below. (This form should be completed by a guardian if the person in question cannot do so.)**

<b>Korean Dementia Screening Questionnaire—C</b>	No (0 point)	Sometimes (1 point)	Almost every day (2 points)
1. I (He/She) do (does) not know what the day is today			
2. I (He/She) cannot find my own things.			
3. I (He/She) ask (asks) the same question over and over.			
4. I (He/She) forget (forgets) appointments.			
5. I (He/She) placed an object and I am (he/she is) not able to recall where the object is placed.			
6. I (He/She) cannot recall people's name or objects' name and has difficult time to say the name.			
7. I (He/She) do (does) not (understand conversations and I (he/she) ask (asks) someone about the conversation over and over.			
8. I (He/She) have (has) gotten lost in the middle of the road.			
9. I've (He/She has) lost the ability to calculate compared to last year. (example: I (he/she) cannot calculate the change or price)			
10. My (His/Her) personality has changed a lot.			
11. I (He/She) am (is) losing my (his/her) ability to use machinery. (washing machine, electric appliance, tracker, etc.)			
12. I (He/She) cannot organize things around the house.			
13. I (He/She) cannot choose the right clothes for the right occasion.			
14. I (He/She) cannot get to the destination alone by public transportation. (except in cases of physical difficulties, such as knee arthritis.)			
15. I (He/She) do (does) not want to change clothes even when they are dirty.			
<b>Score</b>	/ 30		

## Evaluation of Depression for Those Aged 40

The items below are questions about your condition in the last week.

**Please answer how often it happened in the last week.**

**In the last week...**

- ① Rarely (less than once a week)                      ② Sometimes (1-2 days a week)  
 ③ Occasionally (3-4 days a week)                      ④ Almost every day (over 5 days a week)

1. I was annoyed and bothered by things that were okay for me before.	①	②	③	④
2. I did not want to eat and I even lost my appetite.	①	②	③	④
3. I felt sad even when someone tried to help me.	①	②	③	④
4. I could not focus on any work.	①	②	③	④
5. I spent days relatively well.	①	②	③	④
6. I felt so sad.	①	②	③	④
7. I felt everything is so difficult.	①	②	③	④
8. I felt the future was gloomy.	①	②	③	④
9. I felt my whole life was a failure.	①	②	③	④
10. I thought I had the same capability like other people.	①	②	③	④
11. I could not sleep or had sleeping difficulty.	①	②	③	④
12. I felt fear.	①	②	③	④
13. I did not feel like talking as I used to.	①	②	③	④
14. I felt lonely as if I was left alone in the world.	①	②	③	④
15. I lived without major complaints.	①	②	③	④
16. I felt people were unfriendly toward me.	①	②	③	④
17. I burst into tears and felt like crying.	①	②	③	④
18. I felt as if my heart is broken.	①	②	③	④
19. I felt like everyone hated me.	①	②	③	④
20. I did not have any self-confidence to do anything.	①	②	③	④

※ Score: ① (0 point), ② (1 point), ③ (2 points) ④ (3 points) / total 60 points  
**(except Questions 5, 10, and 15 for they are not factors of depression)**

## Evaluation of Depression for those aged 66

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

1. Are you satisfied with your life most of the time?	Yes	No
2. Have you become less active?	Yes	No
3. Do you feel you have not lived as planned?	Yes	No
4. Do you feel life is boring?	Yes	No
5. Do you feel recharged every day?	Yes	No
6. Do you feel nervous about the future?	Yes	No
7. Do you usually feel happy?	Yes	No
8. Do you sometimes feel miserable?	Yes	No
9. Do you want to stay indoors only and not go out all the time?	Yes	No
10. Do you feel your memory is worse than others at your age?	Yes	No
11. Do you feel happy to be alive?	Yes	No
12. Do you feel you are a useless person?	Yes	No
13. Do you have great energy?	Yes	No
14. Do you feel like you do not have any hope?	Yes	No
15. Do you feel your life is worse than others?	Yes	No
Total (Written by Examiner)		
Total Score (Written by Examiner)		

※ Score: Yes (1 point) No (0 point) Total 15 points (except **Questions 1, 5, 7, 11, and 13 for they are not factors of depression**)

(Annex No. 4)

Search for checkup institutions: Home page of NHIS (www.nhis.or.kr) / frequently searched menu / hospitals and checkup institutions / health checkup institutions(Find health checkup institution / hospital.)

**Verification for \_\_\_\_\_ Health Screening Candidate (For Presentation at the Examining Facility)  
(For Corporate Subscribers)**

Name		ID card No.		-1(2)*****		
Name of workplace		Workplace transition No.				
Health insurance No.		Affiliated branch				
Management number of place of business		Work division <sup>1)</sup>		Department		
Address of place of business						
Examination facts and expenses						
1 <sup>st</sup> exam	No charge	Vision, hearing, blood pressure, urine test, blood test, X-ray, oral exam, medical examination by interview, and other medical examinations ※ Examination period: until Dec. 31, _____			Exam for Hepatitis B (aged 40) <sup>2)</sup>	
Oral screening	No charge for a person	Dental examination periodontal tissue examination, <b>dental plaque test</b> (for 40 years old), oral health education, etc. ※ Examination period: until Dec. 31, _____				
2 <sup>nd</sup> exam	No charge	Following the results of the 1 <sup>st</sup> health exam, we work with a person who is suspected of high blood pressure, and/or diabetes. ※ Following the results of the 1 <sup>st</sup> health exam, we work with the evaluation of life habits or mental health of a person who is a special health exam recipient aged 40 or 66. (Examination due by: January, 31, next year)				
Cancer Screening	Category	Stomach Cancer	Colon Cancer	Breast Cancer	Cervical Cancer	Information Agency <sup>3)</sup>
	Candidate/Cost <sup>4)</sup>					
	Medical expenses paid					
	Screening period	Until Dec. 31, _____; the 2 <sup>nd</sup> screening exam for stomach-colon cancer is by January, 31, next year Twice a year for liver cancer: once in the first half (by June 30) and the second half (by December 31)				
※ In case of double examination, we have to charge to recoup additional medical expenses; the National Insurance Cooperation gets medical expenses back from the health exam recipient in the case of taking more than 1 medical checkup per period. (health exam period: office worker—every other year; non office worker—every year) ※ Because a "cancer screening checklist" is sent to the address of the corresponding subjects, please ensure that you do not receive cancer screening twice.						

We confirm the health exam recipient in our office who is on the list above.

year      month      date

President ○○○ (Signature)

Note1) Type of work: write separately for office workers and nonoffice workers (refer to the health exam recipient list)

Note2) Exam on Hepatitis B is only for those aged 40 (except Hepatitis B antigen carrier or antibody carrier)

Note3) Information Agency: the National Cancer Screening results are reported to candidates (public health center)

Note4) Declaration of cost burden.

- ① No cost sharing for examinees: All the cost of the 1st and 2nd general health checkup, the lifetime transition period health checkup, and cervical cancer-related examinations are paid by the corporation. In case of examinations related to the stomach, liver, colon, and breast cancer, 90% is paid by NHIS and 10% by the state.
- ② 10% cost to recipient: NHIS is responsible for 90%, recipient for 10%.
- ③ No application: nonapplicant
- ④ Exam completion: person who is already done with the related exam.
- ⑤ If recipient of medicaid is diagnosed as a new cancer patient as a result of the national cancer screening service, part of the medical expense can be shouldered. (Cannot apply if you do not take the examination this year)
- ※ Age rule for cancer exam: stomach and breast cancer (over 40), colon cancer (over 50), liver cancer (over 40), and cervical cancer (over 20)
- ※ You can check the screening recipient, screening agency, and annual screening result from the Web page of the National Health Insurance Service ([www.nhis.or.kr](http://www.nhis.or.kr)).
- ※ Please observe the health checkup precautions before being examined because the result can be inaccurate if you do not fast for 8 hours, if you had a night shift prior to the checkup, or if you are examined during your menstrual cycle.
- ※ "Liver cancer" is included in the cancer screening checklist, which is sent to the address of the corresponding subjects.
- ※ From 2015, for the office workers who are subjects of cancer screening, the period for their general health checkup and cancer screening is unified on the same year based on their year of birth (even, odd number) to be selected as a subject. (However, the date of birth shall not be classified for the initial examination candidates after employment.)

(AnnexNo.5)

※ Health exams operated by the NHIS can be taken once every 2 years,  
 If a person takes the exam twice or more, we will charge the health exam recipient for the medical expenses.

※ Check information on the NHIS Web site (www.nhis.or.kr) or call our branch office (1577-1000).

printable page (address)  use as a substitute for medical exam list
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----- Do not tear off this paper, this paper can used for the address sheet for results -----

<b>Confirmation _____ for the Health Exam Recipient</b> (use for presentation to examiner)							
Full name				ID No.		-1(2)*****	
<b>Examination facts and expenses</b>							
1 <sup>st</sup> exam	No charge	Vision, hearing, blood pressure, urine test, blood test, X-ray, oral exam, medical examination by interview, and other medical examinations ※ The period of the exam: until Dec. 31, ____			Exam for Hepatitis B (age 40 <sup>1)</sup> )		
Oral screening	No charge for a person	Dental examination periodontal tissue examination, <b>dental plaque test</b> (for 40 years old), oral health education, etc. ※ Examination Period: until Dec. 31, ____					
2 <sup>nd</sup> exam	No charge	Following the results of the 1 <sup>st</sup> health exam, we work with a person who is suspected of high blood pressure and/or diabetes. ※ Following the results of the 1 <sup>st</sup> health exam, we work with the evaluation of life habits or mental health of a person who is a special health exam recipient aged 40 or 66. (Examination Period: January, 31, next year)					
Cancer Screening	Category	Stomach cancer	<u>Liver cancer</u> (first half of the year)	<u>Liver cancer</u> (second half of the year)	Breast cancer	Cervical cancer	Information Agency <sup>3)</sup>
	Candidate / Costs <sup>2)</sup>						
	Medical expenses covered						
	Screening period	Until Dec. 31, _____. The 2 <sup>nd</sup> screening exam for stomach-colon cancer is by January, 31, next year <u>Twice a year for liver cancer: once in the first half (by June 30) and the second half (by December 31)</u>					
As above, we confirm the health exam recipient for _____.							
National Health Insurance Co.				President (signature)			

Note 1) Exam for hepatitis B is only offered to those aged 40 (except hepatitis B antigen carrier or antibody carrier).

Note 2) Declaration of cost burden.

- ① No charge: the NHIS covers the entire expenses for persons who take health exams, such as the 1st and 2nd general health exam, cervical cancer exam, or special health exam for those aged 40, 66, and 70. The NHIS covers 80% and the country covers 20% for persons who are NHIS early cancer exam recipients taking the breast cancer, stomach cancer, liver cancer, and/or colon cancer exams.
- ② Enter out-of-pocket expenses for cancer screening (10% of cancer screening costs).  
 ※ **Ten percent of the costs paid by the recipient may be changed when the “Health Insurance Reimbursement Cost” is revised.**  
 ※ **After calculating the recipient’s fees through additional counseling fees, administrative fees, and examination payments, discount fees that are under KRW 10.**
- ③ No application: nonapplier
- ④ Exam completion: person who is already done with the related exam.
- ⑤ If cancer is confirmed, the patient can get some support for medical expenses. (Cannot apply if you do not take the exam this year)

Note 3) Information agency: the information agency is the place (public health center) for reporting examination results to the NHIS early cancer exam recipient.

- ※ Age rules for cancer examinations: stomach and/or breast cancer (over 40), colon cancer (over 50), liver cancer (over 40), and cervical cancer (over 20)
- ※ You can check the screening recipient, screening agency, and annual screening result from the Web page of the National Health Insurance Service ([www.nhis.or.kr](http://www.nhis.or.kr)).
- ※ If you hadn’t been fasting for more than eight hours prior to the health checkup, if you had the night shift prior to the checkup, or if you were examined during your menstrual cycle, the result may be inaccurate. Please observe the health checkup precautions before your examination.



## Information for Health Exam Recipients

- General Health Examinations provided by the National Health Insurance Service are available every 2 years (every year for all workers except for white-collar workers). Life cycle-based checkups are available at age 40 and 66. The infant and toddler health examination is available for 4, 9, 18, 30, 42, 54, and 66 months of age. Cost for additional health examination unless specified above will be collected.
- When answering the questionnaire, it is very important material for a doctor to diagnose the examinee's condition or examination. Therefore, make sure that all necessary information are written on the sheet.
- The cancer examinations can be provided only for a few of the tests based on your preference and the examinee will need to cover 10% of the medical expenses. (Cost for cervical cancer, subjects of the national cancer screening, and the life cycle-based checkup are 100% covered by NHIS).
- A colorectal cancer test is for those who are over 50 years old. A fecal occult blood test makes up the 1st screening. Only people whose 1st screening turned out to be positive can select either undergo a colon double contrast test or endoscopy as the 2nd test.
- The costs of the general health checkups, lifetime health checkups, [infant/children's health checkup](#), and Pap smear will be fully covered by the National Health Insurance Service.
- Life cycle-based checkups are only available once in corresponding age, in other words, once in a lifetime.
- People who are taking the 1st special health exam will be the next health exam recipients. The prescription for improving life habits through the evaluation (smoking, drinking alcohol, exercising, overweight, nutrition) cannot be used for medication or drugs.
- Please follow the health exam regulations. Results will be inaccurate if people do not have an empty stomach over 8 hours before the health exam, have worked overnight, or have taken the health exam during their period (for women).

## Smoking Habits Evaluation

Examinee's name

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

**1. Do you plan to stop smoking?**

- ① I plan to stop smoking within a month.
- ② I plan to stop smoking within 6 months.
- ③ I am thinking about stopping, but not within 6 months
- ④ I do not have any intention to stop smoking right now.

**2. Can you stop smoking right now (0-7)?**

- 0    1    2    3    4    5    6    7

(Not at all)

(For sure)

**3. How soon do you light up your first cigarette after waking up?**

- Within 5 minutes (3 points)
- Between 6-30 minutes (2 points)
- Between 31-60 minutes (1 point)
- After 60 minutes (0 point)

**4. Do you have difficulty holding the urge to smoke in nonsmoking areas, such as churches, theaters, or libraries?**

- Yes (1 point)
- No (0 point)

**5. In which occasion is it most difficult for you to give up smoking?**

- The first cigarette in early morning (1 point)
- Others (0 point)

**6. How many cigarettes do you smoke a day?**

- Under 10 cigarettes (0 points)
- 11-20 cigarettes (1 point)
- 21-30 cigarettes (2 points)
- Over 31 cigarettes (3 points)

**7. Do you smoke more cigarettes within a few hours after waking up than the later hours?**

- Yes (1 point)
- No (0 points)

**8. Do you still want to smoke even when you are very sick?**

- Yes (1 point)
- No (0 point)

**Total**

## Smoking Cessation Prescription

**Date of visiting:**  
**Examinee name:**                      **Gender: Male/ Female**

**1. Present smoking status**

- Ex-smoker                                       Light smoker                                       Heavy smoker

**2. Nicotine dependency**

- Low     Medium     high

**You can improve your quality of life if you stop smoking.**

**3. Smoking prescription**

- Need education or counseling to stop smoking. Please read the stop-smoking brochure.  
 Need nicotine replacement therapy.

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- Need to take medication to aid smoking cessation (i.e., Bropion).

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- Refer to smoking cessation services (i.e., smoking cessation clinic or smoking cessation call center or quitline).  
 Others: \_\_\_\_\_

**4. Status of health problems that can be improved when one stops smoking.**

- |  |   |
|--|---|
| <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> Diabetes                           |
| <input type="checkbox"/> Heart disease             | <input type="checkbox"/> Hyperlipidemia                     |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Peripheral circulatory disturbance |
| <input type="checkbox"/> Chronic bronchial trouble | <input type="checkbox"/> Asthma                             |
| <input type="checkbox"/> Paranasal sinusitis       | <input type="checkbox"/> Gastric/Duodenal ulcer             |
| <input type="checkbox"/> Surgery complication      | <input type="checkbox"/> Family health                      |
| <input type="checkbox"/> Bad breath                | <input type="checkbox"/> Decrease of immune function        |
| <input type="checkbox"/> Wound healing retardation | <input type="checkbox"/> Sexual impotence                   |
| <input type="checkbox"/> Lumbago & ruptured disk   | <input type="checkbox"/> Osteoporosis                       |
| <input type="checkbox"/> Others: _____             |   |

**You might require regular clinic visits to assist you with smoking cessation.**

**Physician's name:** \_\_\_\_\_ (signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

### Alcohol Habit Evaluation

Examinee's name	
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**Please answer the following questions about your present condition by ticking the appropriate box.**

**1. How often do you drink alcoholic beverages?**  
 Never (0 point)     Less than once a week (1 point)     2-4 times a month (2 points)  
 2-3 times a week (3 points)     Over 4 times a week (4 points)

**2. How many alcoholic beverages do you have in a typical day when you drink?**  
(Regardless of the types of alcohol beverages, count the total number of glasses. For beer, 1 can of beer, 350 cc of draft beer, or 1 bowl of Mak-Gul-li, is counted as 1 glass)  
 1-2 (0 point)     3-4 (1 point)     5-6 (2 points)  
 7-9 (3 points)     over 10 (4 points)

**3. How often do you have 6 or more drinks in 1 occasion?**  
 Never (0 point)     Less than once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**4. How often during the last year have you found yourself not able to stop drinking once you started?**  
 Never (0 point)     Less than once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**5. How often during the last year have you failed to perform you daily work because of drinking?**  
 Never (0 point)     Less than once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session from the previous night?**  
 Never (0 point)     Less than once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**7. How often during the last year have you had a feeling of guilt or remorse after drinking?**  
 Never (0 point)     Under once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?**  
 Never (0 point)     Less than once a month (1 point)     Once a month (2 points)  
 Once a week (3 points)     Almost every day (4 points)

**9. Have you or someone else been injured a result of your drinking?**  
 No (0 point)     Yes, but not in the last year. (2 points)  
 Yes, during the last year. (4 points)

**10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you to cut down?**  
 No (0 point)     Yes, but not in the last year. (2 points)  
 Yes, during the last year. (4 points)

<b>Total</b>	
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## Stop Drinking or Drinking in Moderation Prescription

Date of visit:

Examinee's name:

Gender: male/female

### 1. Present drinking state

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Normal            | <input type="checkbox"/> Danger    |
| <input type="checkbox"/> Misuse of alcohol | <input type="checkbox"/> Alcoholic |

### 2. Stop drinking or drinking in moderation prescription

#### 1) Need education or counseling

- Certainly need to stop drinking for (      ) days.
- Never drink over (      ) glasses a day, never drink a total of (      ) glasses a week.
- Keep discontinuation for a total of (      ) days a week.
- Bring a written drinking diary for 2 weeks.
- Read the nondrinking brochure.

#### 2) Need to take medicine or drugs

- Prescribe medicine for reducing drinking desire

\_\_\_\_\_

- Others: \_\_\_\_\_

### 3. Health problems that can be improved when one stops drinking

- |   |  |
|---|--|
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Stomach disease           |
| <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Heart disease             |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Stroke                    |
| <input type="checkbox"/> Hyperlipidemia         | <input type="checkbox"/> Osteoporosis              |
| <input type="checkbox"/> Overweight             | <input type="checkbox"/> Problems relevant to work |
| <input type="checkbox"/> Interpersonal relation | <input type="checkbox"/> Accidents                 |
| <input type="checkbox"/> Others:                |  |

 **We advise you to get additional professional help**

Physician's name:

(signature)



## Prescription for Exercise Habits

**Date of visit:**

**Examinee's name:**

**Gender: Male/Female**

### 1. Present exercise status

- Insufficient for maintaining health.
- Not enough to improve your health although health can be maintained.
- Improving your health.

### 2. We recommend the following types of exercises to improve your health and quality of life.

#### 1) Types of exercise you should do

- Fast walking       Walking       Mountain hiking
- Swimming       Water activities       Riding a bicycle
- Aerobics       Dance       Yoga
- Weights       Others:

#### 2) Exercise duration

- 10 minutes       15-30 minutes       Over 30 minutes       Others:

#### 3) Exercise frequency

- 1-2 times a week       3-4 times a week       over 5 times a week

### 3. Health problems or conditions can be improved through exercise.

- Overweight       Stress       High blood pressure
- Diabetes       Heart disease       Stroke
- Hyperlipidemia       Osteoporosis       Pain in bones or joints
- Injury from a fall       Depression       Others

**Physician's name:**

(Signature)

## Evaluation of Diet Habits

Examinee's name		I would like to take the Evaluation of Diet Habits. <input type="checkbox"/>
<b>Please answer the following questions about your present condition by ticking the appropriate box.</b>		
<b>1. I drink dairy products, such as milk, soybean milk, among others, more than 1 glass (over 200 ml) every day.</b>		
<input type="checkbox"/> Usually (5 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (1 point)
<b>2. I eat meat, fish, egg, bean, or tofu more than 3 times a day.</b>		
<input type="checkbox"/> Usually (5 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (1 point)
<b>3. I include vegetables in every meal.</b>		
<input type="checkbox"/> Usually (5 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (1 point)
<b>4. I eat fruit (more than 1 serving) or drink fruit juice every day.</b>		
<input type="checkbox"/> Usually (5 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (1 point)
<b>5. How often do you have stir-fried food?</b>		
<input type="checkbox"/> More than 4 times a week (1 point)	<input type="checkbox"/> 2-3 times a week (3 points)	
<input type="checkbox"/> Less than 1 time a week (5 points)		
<b>6. How often do you have food containing cholesterol, such as bacon, egg yolk, squid, etc.?</b>		
<input type="checkbox"/> More than 4 times a week (1 point)	<input type="checkbox"/> 2-3 times a week (3 points)	
<input type="checkbox"/> Less than once a week (5 points)		
<b>7. I eat one of these—ice cream, cake, snack or drinks (coffee, cola, sweet drinks)—every day.</b>		
<input type="checkbox"/> Usually (1 point)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (5 points)
<b>8. I eat salted fish, soy sauce-seasoned dried vegetables, and other salty foods.</b>		
<input type="checkbox"/> Usually (1 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (5 points)
<b>9. I always have my meals on time.</b>		
<input type="checkbox"/> Usually (5 points)	<input type="checkbox"/> Sometimes (3 points)	<input type="checkbox"/> Never (1 point)
<b>10. Do you eat at least 1 of each of the food groups, such as dairy products, meat or fish, fruits, vegetables, and grain, every day?</b>		
<input type="checkbox"/> 5 types (5 points)	<input type="checkbox"/> 4 types (3 points)	<input type="checkbox"/> less than 3 types (1 point)
<b>11. How often do you eat out?</b>		
<input type="checkbox"/> More than 5 times a week (1 point)	<input type="checkbox"/> 2-4 times a week (3 points)	
<input type="checkbox"/> Less than once a week (5 points)		
		<b>Total</b> <input type="text"/>

## Prescription for Nutritional Life Habits

**Date of visit:**

**Examinee's name:**

**Gender: male/female**

### 1. Present diet habits

- Needs much improvement.
- Normal.
- Can prevent disease and maintain health.

### 2. Improvement of diet habits.

- Drink more than 1 glass of milk, low-fat milk, or soybean milk containing calcium every day.
- Eat a small portion of meat, tofu, bean, or fish more than 3 times a day.
- Have vegetables during every meal.
- Eat more than 1 serving of fruit and drink more than 1 glass of fruit juice.
- Have seasoned, steamed, or roasted dishes, rather than fried dishes.
- When you eat meat, if possible, eat lean meat and eat chicken and duck without the skin. Do not often eat eel, fish stomach, and fish eggs.
- Do not have any sugary snacks, such as ice cream, snacks, or cake.
- Eat more solid food items rather than soup and reduce intake of salty food.
- Never skip breakfast and have regular meals.
- Keep a balanced diet.
- If possible, cut the number of times you eat out and if you do eat out, please avoid food that is too salty, too spicy, or too oily.
- Drink at least 8 glasses of water every day (general recommendation).

### 3. Health problems or conditions that can be improved through healthy eating habits.

- |  |  |
|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes                        |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Hyperlipidemia                  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Peripheral blood vessel trouble |
| <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Overweight                      |
| <input type="checkbox"/> Gout                | <input type="checkbox"/> Others                          |

**Physician's name:**

(Signature)

## Evaluation of Weight Control Habits

Examinee's name		I would like to take the Evaluation of Weight Control Habits. <input type="checkbox"/>
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Please answer the following questions about your present condition by ticking the appropriate box.

◆ Height: \_\_\_\_\_ cm

◆ Weight: \_\_\_\_\_ kg

◆ Waist: \_\_\_\_\_ cm

◆ Body mass index: \_\_\_\_\_ kg/m<sup>2</sup>

1. Do you weigh more (10 kg) now than when you were in your teens or early 20s?

Yes

No

2. How many times have you tried to lose weight?

Never

1-3

Over 4

Always

3. Are you interested in losing weight?

No

A little bit interested

Very interested

## Weight Control Prescription

**Date of visit:**

**Examinee's name:**

**Gender: Male/Female**

◆ **Height:** \_\_\_\_\_ **cm**

◆ **Weight:** \_\_\_\_\_ **kg**

◆ **Waist:** \_\_\_\_\_ **cm**

◆ **Body mass index:** \_\_\_\_\_ **kg/m<sup>2</sup>**

**1. You are**

- underweight.                       normal  
 overweight.                       obese.

**2. You have excessive fat around the abdomen.**

- Yes                                       No

**3. Because of your weight, your risk level of developing chronic diseases, such as CVDs, hypertension, diabetes, high cholesterol, among others, is**

- low.                                       normal.                                       a little increased.  
 more increased.                       sharply increased.                       very sharply increased.

**4. Recommended weight goal:**

- We recommend to lose your weight down to (                      )% as the first goal.  
 Your first weight goal is                      kg.  
 The period of primary weight loss is within                      months.  
 Weight loss each month is                      kg.

**5. Prescription to treat obesity**

- Reduce meal portions     Reduce snacks or midnight munchies  
 Reduce eating out or fast food  
 Smoking                       Drinking                       Exercising                       Get nutrition prescription  
 Need to take medication  
 Others:

**6. Health problems or conditions that can be improved if you keep the normal range of weight after weight loss.**

- Angina pectoris / cardiac infarction                       Diabetes                       Stroke  
 High blood pressure                       High cholesterol                       Peripheral blood vessel disease  
 Sleep apnea syndrome                       Incontinence                       Spine or bone problems  
 Gallbladder stone                       Others:

 **You need regular clinic visits to assist you in losing weight.**

**Physician's name:**

(Signature)