

General Health Checkup Report

| | | | |
|---------------------|--|------------------------------|---|
| Subject name | | Resident registration number | |
| Date of examination | | Health checkup institution | <input type="checkbox"/> Visit <input type="checkbox"/> On-site checkup |

Health Checkup General comments

Determination — ☐ Normal A ☐ Normal B (boundary)
☐ General disease ☐ Hypertension or diabetes mellitus suspected ☐ Abnormal
(Diagnostic test required)

- ◆ ○○○ received general health examination and other , , tests.
* Please refer to the results and prescription of assessment of life habits for your assessment of life habits.

- ◆ Mr./Mrs./Ms. , you are in need of health care relating to the following matters.

▷ Suspected Illness:

* If you are diagnosed with suspected hypertension or diabetes mellitus, you may receive a diagnostic test at a nearby hospital or clinic. The medical bills of your first visit for a diagnostic test are subsidized (You should have a test before January 31 the following year.)
If you are an eligible recipient of medical benefits, you may receive a diagnostic test at a nearby clinic in accordance with the Medical Care Assistance Act.

▷ Illness confirmed:

▷ Management of life habits

▷ Others

*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 | Result (reference value) | | | |
|--|---|---|--|---|---|---|
| Measuring examination | Obesity/ Abdominal obesity | Height (cm) / weight (kg) | / | | | |
| | | BMI (kg/m ²) | <input type="checkbox"/> Underweight (below 18.5) | <input type="checkbox"/> Normal (18.5-24.9) | <input type="checkbox"/> Overweight (25-29.9) | <input type="checkbox"/> Obesity (30 and over) |
| | | waist (cm) | <input type="checkbox"/> Normal | | | <input type="checkbox"/> Abdominal obesity (Male: 90 and over; Female: 85 and over) |
| | Abnormality of visual acuity | Visual acuity (left/right) | / | <input type="checkbox"/> corrected | | |
| | Abnormality of auditory acuity | Auditory acuity (left/right) | / | <input type="checkbox"/> Normal | <input type="checkbox"/> Disease suspected | |
| | Hypertension (systole/diastolic) | / mmHg | <input type="checkbox"/> Normal <input type="checkbox"/> Hypertension <input type="checkbox"/> Prehypertension (systole: 120-139, or diastolic: 80-99) <input type="checkbox"/> Hypertension suspected (140 and over or 90 and over) | | | |
| Blood test | Anemia | Hemoglobin (g/dL) | | Male: 13-16.5 Female: 12-15.5 | <input type="checkbox"/> Normal <input type="checkbox"/> Anemia suspected <input type="checkbox"/> Others | |
| | Diabetes Mellitus | Fasting blood sugar (mg/dL) | | Below 100 | <input type="checkbox"/> Normal <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Impaired fasting glucose suspected <input type="checkbox"/> Diabetes mellitus suspected | |
| | Dyslipidemia | Total cholesterol (mg/dL) | | Below 200 | <input type="checkbox"/> Normal <input type="checkbox"/> Hypercholesterolemia suspected <input type="checkbox"/> Hypertriglyceridemia suspected <input type="checkbox"/> Low HDL cholesterol suspected <input type="checkbox"/> Diabetes mellitus | |
| | | HDL cholesterol (mg/dL) | | Below 60 | | |
| | | Triglyceride (mg/dL) | | Below 150 | | |
| | | LDL cholesterol (mg/dL) | | Below 130 | | |
| | Kidney disease | Serum creatinine (mg/dL) | | 1.5 and below | <input type="checkbox"/> Normal <input type="checkbox"/> Kidney disease suspected | |
| | | Glomerular filtration rate (e-GFR) (mL/min/1.73 m ²) | | 60 and over | | |
| | Liver disease | AST(SGOT)(IU/L) | | 40 and below | <input type="checkbox"/> Normal <input type="checkbox"/> Liver disease suspected | |
| | | ALT(SGPT)(IU/L) | | 35 and below | | |
| | | Gamma-GTP (γGTP)(IU/L) | | Male: 63 and below Female: 35 and below | | |
| | Urinalysis | Proteinuria | <input type="checkbox"/> Normal <input type="checkbox"/> Boundary <input type="checkbox"/> Proteinuria suspected | | | |
| Radiography | Chest radiograph | <input type="checkbox"/> Normal <input type="checkbox"/> Inactive pulmonary tuberculosis <input type="checkbox"/> Disease suspected: <input type="checkbox"/> Others: | | | | |
| Physical examination (questionnaire) | Past medical history diagnosis | | | Medication therapy | | |
| | Lifestyle | <input type="checkbox"/> Smoking abstinence required <input type="checkbox"/> Drinking restriction required <input type="checkbox"/> Exercise required <input type="checkbox"/> Muscle exercise required * Consult your physician. | | | | |
| | Applicability | | Result | | | |
| Hepatitis B | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | Surface antigen | <input type="checkbox"/> General <input type="checkbox"/> Precise () | | | |
| | | Surface antibody | <input type="checkbox"/> General <input type="checkbox"/> Precise () | | | |
| | | <input type="checkbox"/> Antibody detected <input type="checkbox"/> Antibody not detected | <input type="checkbox"/> Hepatitis B virus antigen carrier suspected <input type="checkbox"/> Diagnosis deferred | | | |
| Depression | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | <input type="checkbox"/> No symptoms of depression (0~4 points) <input type="checkbox"/> Light symptoms of depression (5~9 points) <input type="checkbox"/> Moderate depression suspected (10~19 points) <input type="checkbox"/> Severe depression suspected (20~27 points) | | | | |
| Cognitive function disorder | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | <input type="checkbox"/> No specific abnormality (0~5 points) <input type="checkbox"/> Cognitive function disorder suspected (6 points and over) | | | | |
| Bone density test | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | | <input type="checkbox"/> Normal | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Osteoporosis | |
| Physical functional assessment of elderly | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | <input type="checkbox"/> Normal <input type="checkbox"/> Physical functions degraded | | | | |
| Functional assessment of elderly (questionnaire) | <input type="checkbox"/> Applicable <input type="checkbox"/> Not applicable | Fall | <input type="checkbox"/> Normal <input type="checkbox"/> High risk of fall | | | |
| | | Ability to perform daily living activities | <input type="checkbox"/> Normal <input type="checkbox"/> In need of daily living assistance | | | |
| | | Vaccination | <input type="checkbox"/> Influenza vaccine inoculation required <input type="checkbox"/> Pneumococcal vaccine inoculation required <input type="checkbox"/> Vaccine inoculation not required | | | |
| | | Micturition disorder | <input type="checkbox"/> Normal <input type="checkbox"/> Micturition disorder suspected | | | |

Cardiovascular Disease Risk Assessment

*Cardiovascular disease refers to ailments including stroke, myocardial infarction, etc.

| | | | |
|------|-----|-----|--------------------------------|
| Name | Sex | Age | Date of examination 0000-00-00 |
|------|-----|-----|--------------------------------|

| | | |
|---|--|---|
| Risk of cardiovascular disease | | |
| Your risk of cardiovascular disease (Compared to average for your (age) (sex)) 0.00 times | Probability that you develop cardiovascular disease within 10 years Mr./Mrs./Ms. 0.0% Average for your (age)(sex) 0.0% | Cardiovascular age 00 years |

| Learn about health related factors | | | |
|--|-------------------|-----------------------------|--|
| Health related factors | Current condition | → Target condition | Health signals |
|  Weight Waist line | | Below 65kg Below 90cm |  위험 Danger |
|  Exercise | | Five or more times per week |  위험 Danger |
|  Drinking | | Not more than 2 glasses |  위험 Danger |
|  Blood pressure | | Below 120/80 |  위험 Danger |
|  Smoking | | Sustain nonsmoking |  주의 Caution |
|  Fasting blood sugar | | Below 100 |  주의 Caution |
|  Total cholesterol LDL cholesterol | | Below 200 Below 130 |  안전 Safe |

Mr./Mrs./Ms. , the results above are your current health conditions and goals based on your questionnaire answers and test results. You will need to actively improve the items corresponding to the health signals “Caution” or “Danger”. If you are taking any medication for hypertension, diabetes mellitus, or dyslipidemia, your health signal result will be “Caution” even when your blood pressure, fasting blood sugar level, and cholesterol fall within the goal ranges. Please continue to manage your health conditions.

※ As the goals above follow the general guidelines, they may vary depending on your health conditions. Please consult your physician.

| | |
|---|--------------------------------------|
| To improve health related factors | |
| The probability that you develop cardiovascular disease within 10 years should decrease by 00% (0.0% → 0.0%) | Cardiovascular age 00 → 00 |

This certifies the information above as your health checkup results.

20

Date of assessment: Physician: License (Qualification) / No. Name (Signature)
(Medical Care Institution)

Assessment Results of Life Habits

| | | | |
|---------------------|--|------------------------------|---|
| Subject name | | Resident registration number | |
| Date of examination | | Health checkup institution | <input type="checkbox"/> Visit <input type="checkbox"/> On-site checkup |

| | | | |
|---------|---|---|--|
| Smoking | <input type="checkbox"/> Nonsmoker <input type="checkbox"/> Former smoker <input type="checkbox"/> Current smoker <input type="checkbox"/> Smoker using e-cigarettes only | | |
| | Nicotine dependence assessment | <input type="checkbox"/> Low (0~3 points) <input type="checkbox"/> Middle (4~6 points) <input type="checkbox"/> High (7~10 points) | |
| | Prescription for quitting smoking | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Prescription | <input type="checkbox"/> Consultation and education <input type="checkbox"/> Medication therapy (nicotine replacement therapy, bupropion, and varenicline) <input type="checkbox"/> Referral (nonsmoking center and clinic) | |

| | | | |
|---------------------|--|--|--|
| Alcohol consumption | <input type="checkbox"/> Non-drinker <input type="checkbox"/> Light drinker <input type="checkbox"/> Heavy drinker <input type="checkbox"/> Alcohol use disorder suspected | | |
| | Prescription for quitting drinking/restricting drinking | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | Prescription | <input type="checkbox"/> Consultation and education <input type="checkbox"/> Referral (alcohol rehab center and clinic) <input type="checkbox"/> Medication therapy | |

| | | |
|----------|---|---|
| Exercise | <input type="checkbox"/> Lack of exercise <input type="checkbox"/> Basic exercise <input type="checkbox"/> Exercise for promotion of health | |
| | <input type="checkbox"/> Lack of muscle exercise <input type="checkbox"/> Proper muscle exercise | |
| | Exercise prescription | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Prescription | <input type="checkbox"/> Power walking <input type="checkbox"/> Swimming <input type="checkbox"/> Mountain climbing <input type="checkbox"/> Aerobics Type: <input type="checkbox"/> Stretching <input type="checkbox"/> Muscle exercise <input type="checkbox"/> Others () |
| | Time: <input type="checkbox"/> 10 minutes <input type="checkbox"/> 15~30 minutes <input type="checkbox"/> Over 30 minutes <input type="checkbox"/> Others () Frequency: <input type="checkbox"/> 1~2 times a week <input type="checkbox"/> 3~4 times a week <input type="checkbox"/> More than 5 times a week | |

| | | |
|-----------|---|---|
| Nutrition | <input type="checkbox"/> Good <input type="checkbox"/> Normal <input type="checkbox"/> Poor | |
| | Nutrition prescription | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Prescription | <input type="checkbox"/> Please increase food intake. (<input type="checkbox"/> Dairy <input type="checkbox"/> Proteins <input type="checkbox"/> Vegetables) <input type="checkbox"/> Please decrease (<input type="checkbox"/> Fat <input type="checkbox"/> Simple sugar <input type="checkbox"/> Salinity (salt)) <input type="checkbox"/> Healthy eating habits (<input type="checkbox"/> Not skipping breakfast <input type="checkbox"/> Eating a balanced variety of foods) <input type="checkbox"/> Referral (Nutrition education class) |

| | | |
|---------|---|--|
| Obesity | <input type="checkbox"/> Normal weight <input type="checkbox"/> Overweight <input type="checkbox"/> Obesity | |
| | Prescription for obesity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | Prescription | <input type="checkbox"/> Please decrease the amount of food intake. <input type="checkbox"/> Please decrease daytime and nighttime snacks. <input type="checkbox"/> Please decrease the amount and frequency of alcohol consumption. <input type="checkbox"/> Please decrease dining out and fast food intake. <input type="checkbox"/> Please refer to the exercise prescription. <input type="checkbox"/> Referral (Obesity clinic) <input type="checkbox"/> Others () |