일반건강진단문진표(Health checkup questionnaire)

□일반 □생습 □암(□위,□대장,□유장,□자궁) □보건증 □뇌심 □직무 □생애 □우울 □인지 □노인신체
□ 일반비대상 □타기관수검완료

검체번호	
검진장소	
결과발송	□모바일 □우편발송 □이메일

Last Name	
Given Name	
Resident Reg. No..	
Mobile phone	
E-mail	

검진항목·비용		항목	비용부담
	건강검진	일반건강검진	본인부담없음
		의료급여생애전환기검진	본인부담없음
	암검진	위암	
		간암	
		대장암	
		유방암	
		자궁경부암	

사업체명		지점		부서	

공단검진항목

신장 □본인기재	cm	체중 □본인기재	kg	체질량지수 BMI		허리둘레 □본인기재	
시력(좌/우) □교정	/	청력 □교정	좌 : ①정상 ②비정상( ) 우 : ①정상 ②비정상( )			혈압	① / ② /
요단백	□음성 □± □1+ □2+ □3+ □4+			흉부X-rat 촬영번호			

※ Please make sure to fill out the red border part.

노인신체	하지기능	일어나서 3m 걷고 돌아와서 앉기	초	보행장애	□유 □무	
	평형성(한다리로 서기)	눈감은상태	초	눈뜬상태	초	

일반문진		
	과거병력	(진단) 1. 무 2. 유(①뇌졸중 ②심장병③고혈압④당뇨병⑤이상지질혈증⑥폐결핵⑦기타(암포함))
	가족력	(약물) 1. 무 2. 유(①뇌졸중 ②심장병③고혈압④당뇨병⑤이상지질혈증⑥폐결핵⑦기타(암포함))
	B형간염(바이러스보유)	①예 ②아니오 ③모름
	생활습관	①금연필요 ②절주필요 ③신체활동필요 ④근력운동필요

Date		Subject name	(Signature)	검진의	면허번호	
					서명	(서명)

의료법인 인봉의료재단 영등포병원
Youngdeungpo Hospital Corporation

Health checkup questionnaire

※ Examinees must complete the questionnaire to receive the results of the cardiovascular disease risk assessment.

Last Name		Resident Reg. No..		Telephone	Home	
Given Name					Mobile phone	
Current address				E-mail		
				How to receive a health checkup report	□ Post □ E-mail	

※ Please answer all the questions below.

Medical history (disease history, family history)

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

	Diagnosis		Medication therapy	
Brain stroke (paralysis)	Yes	No	Yes	No
Cardiac infarction/angina	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No
Dyslipidemia	Yes	No	Yes	No
Tuberculosis	Yes	No	Yes	No
Others (including cancer)	Yes	No	Yes	No

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

Brain stroke (paralysis)	Yes	No
Cardiac infarction/angina	Yes	No
High blood pressure	Yes	No
Diabetes	Yes	No
Others (including cancer)	Yes	No

3. Are you a Hepatitis B virus antigen carrier?

① Yes ② No ③ No idea

Smoking and e-cigarettes (vaping)

4. Have you ever smoked more than 5 packs of cigarettes (100 cigarettes) in your lifetime?

① No. (☞ Go to Question 5)
② Yes. (☞ Go to Question 4-1)

4-1. Do you smoke cigarettes now?

① I do	A total of ____ years	An average of _____ cigarettes a day	
② I used to but not anymore	A total of ____ years	Used to smoke _____ cigarettes a day on average	____ years since I quitted

5. Have you ever smoked an electronic cigarette (e.g., IQOS, Glo, or Lil)?

① No. (☞ Go to Question 6)
② Yes. (☞ Go to Question 5-1)

5-1. Do you smoke electronic cigarettes now?

① I do	A total of ____ years	An average of _____ cigarettes a day	
② I used to but not anymore	A total of ____ years	Used to smoke _____ cigarettes a day on average	____ years since I quitted

6. Have you ever used a liquid electronic cigarette?

① No.
② Yes. (☞ Go to Question 6-1)

6-1. Have you used a liquid electronic cigarette in the last month?

① No ② 1 to 2 days per month ③ 3 to 9 days per month
④ 10 to 29 days per month ⑤ Every day

Drinking

※ In the past one year

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

① ( ) times per week ② ( ) times per month
③ ( ) times per year
④ I don't drink alcohol.

7-1. How many drinks containing alcohol do you have on a typical day when you are drinking?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types; choose a similar type for other liquor types that are not indicated)

Type of liquor	Glass	Bottle	Can	cc
Soju				
Beer				
Hard liquor				
Makgeolli (rice wine)				
Wine				

7-2. What is the largest amount of drinks containing alcohol that you have ever had in one day?

* Choose one among the glass, bottle, can, or cc (you can choose more than one for liquor types, choose a similar type for other liquor types that are not indicated)

Type of liquor	Glass	Bottle	Can	cc
Soju				
Beer				
Hard liquor				
Makgeolli (rice wine)				
Wine				

Exercising

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

( ) days per week

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

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

( ) hours ( ) minutes per day

9-1. How often do you do moderate intensity exercise (making you slightly short of breath) per week?

( ) days per week

* Exclude exercise you have already written in Question 8
* Examples of moderate intensity exercise> Power walking, doubles tennis games, cycling at normal speed, carrying light items, cleaning, etc.

9-2. How long do you do moderate intensity exercise (making you slightly short of breath) per day?

( ) hours ( ) minutes per day

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

( ) days per week

Mental Health (Depression) Assessment Tool

Patient Health Questionnaire-9: PHQ-9

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

How often have you suffered from the following symptoms **over the past two weeks**?

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

Dental Health Screening Program

Last Name		Resident Reg. No..		Telephone	Home	
Given Name					Mobile phone	
Current address				E-mail		
				How to receive a health checkup report	□ Post □ E-mail	

These are questions about your dental history and awareness about your oral health.

1. Have you visited a dental clinic during the last year?
① Yes ② No

2. Do you have diabetes?
① Yes ② No ③ I do not know

3. Do you have cardiovascular disease(s)?
① Yes ② No ③ I do not know

4. Do you have any difficulties in chewing food because of your teeth, gums, or dentures for the last 3 months?
① Yes ② No

5. Have you had a toothache or soreness for the last 3 months?
① Yes ② No

6. Have you had any pain or bleeding in your gums?
① Yes ② No

7. How do you describe your oral health, including your teeth and gums?
① Excellent ② Good ③ Normal
④ Not well ⑤ Never been worse

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

8. Have you learned how to brush teeth from a dental clinic or health center?
① Yes ② No

9. How many times did you brush your teeth yesterday?
( ) times

10. How often did you brush your teeth before going to bed during last week?
① Every day (7 times) ② Almost every day (4~6 times)
③ Occasionally (1~3 times) ④ Never (0 times)

11. How often did you use dental floss or floss brush during the last week?
① Every day ② Almost every day
③ Occasionally ④ Never
⑤ I do not know what a dental floss or floss brush is.

12. Does your toothpaste contain fluoride?
① Yes ② No ③ I do not know

13. How many times do you consume sweets or sticky snacks, such as cookies, candies, and cakes, per day?
① Never ② Once ③ 2~3 times
④ More than 4 times ⑤ I do not know

14. How many times do you drink soda or sweet drinks (including sports drink, ion supply drinks, and fruit juices)?
① Never ② Once ③ 2~3 times
④ More than 4 times ⑤ I do not know

15. Do you smoke?
① Never smoked ② Currently smoke
③ Smoked in the past but stopped

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

Dental Health Screening Program

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15. Do you smoke?
① Never smoked ② Currently smoke
③ Smoked in the past but stopped

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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 medical care turning point checkup), ☐ Cancer screening, ☐ Health checkup for infants〕

This form is used to obtain your informed consent on:

- The **provision of screening result** from the National Health Insurance Service (NHIS) to a public health center as well as of health management service history from a public health center to NHIS 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 (including medical care turning point checkup) 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 provision of screening result from the NHIS to the National Cancer Center (NCC) and/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;**
- **The provision of screening result from the NHIS to the Korea Centers for Disease Control & Prevention (KCDC) and/or a public health center so that post-management can be provided to subjects who are suspected or determined to have pulmonary tuberculosis (TB) based on the result of the general health checkup.**

*** 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 NHIS 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 NHIS and consent to provide related details that I have been notified of.

① Institutions providing information: public health center, NCC, KCDC and NHIS

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), to provide post-management based on the cancer screening result, and to provide pulmonary TB-related post-management.

③ Personal information willing to provide

- NHIS → Public health center
- Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., health checkup results and questionnaire data
- Public health center → NHIS: Name, resident registration number, health service management details provided by the public health center
- NHIS → NCC and/or public health center
- Personal identification information, such as name, resident registration number, address, telephone number, e-mail, etc., cancer screening results and questionnaire data
- NHIS → KCDC and/or public health center
- Personal identification information, such as name, resident registration number, address, telephone number, e-mail address, and chest radiography results and pulmonary TB-related 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 terms. ☐

Year Month Day

Consent	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)				