HIF Medical Report — Due: April 30, 2024

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

Patient's Name _____ Height _____ Weight _____ BP _____

Date of Examination _____ How long have you known the patient? _____

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

Has the patient:

had any past surgeries? ☐ Yes ☐ No ☐ N/A
had asthma? ☐ Yes ☐ No ☐ N/A
had psychological or psychiatric treatment? ☐ Yes ☐ No ☐ N/A
ever been hospitalized? ☐ Yes ☐ No ☐ N/A
had an anaphylactic reaction? ☐ Yes ☐ No ☐ N/A

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

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

Please mark all conditions that CURRENTLY affect this patient:

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

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

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

☐ To the best of my knowledge, the above named patient has no physical or psychological conditions that would prevent him/her from participating successfully in an eight-week study program in Japan.

☐ I do not recommend that this applicant participate in an eight-week study program in Japan due to present health conditions.

Physician's Signature _____ Date _____

Physician's Name (please print) _____

Physician's Address _____

Physicians Tel & E-mail address _____

Hokkaido International Foundation (HIF)
14-1 Motomachi, Hakodate, Hokkaido 040-0054 Japan
Tel: 81-138-22-0770 **Fax: 81-138-22-0660** **E-mail: jj@hif.or.jp**

HOKKAIDO INTERNATIONAL FOUNDATION