General health checkup questionnaire

※ Make sure that the writing is thick and accurate in the check box (☐) with a black pen (ex : ☑ ■ ◉ ☒)

Make sure to mark the inside of the check box.

Day of examination			
Name		Gender	☐ male ☐ female
Date of birth			
Phone No.			

[Barcode]

[Medical history (disease history, family history)]

※ Please answer all the questions below.

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		Diagnosis	Medication therapy
Brainstroke (paralysis)	☐	☐	Dyslipidemia	☐	☐
Cardiac infarction /angina	☐	☐	Tuberculosis	☐	☐
High blood pressure	☐	☐	Others (including cancer)	☐	☐
Diabetes	☐	☐			

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

Brainstroke (paralysis)	☐	Diabetes	☐
Cardiac infarction /angina	☐	Others (including cancer)	☐
High blood pressure	☐		

3. Are you a Hepatitis B virus antigen carrier?

☐ Yes ☐ No ☐ No idea

[Smoking and e – cigarettes (vaping)]

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

☐ No, I never smoked. (☞ Go to Question 5)

☐ Yes, I used to smoke but I stopped. (☞ Go to Question 4-1)

4-1. If you used to smoke but stopped, please answer the following. For how many years had you smoked?

☐ I do	A total of years	An average of cigarettes a day	
☐ 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)?

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

5-1. Do you smoke electronic cigarettes now?

☐ I do	A total of years	An average of cigarettes a day	
☐ 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?

☐ Yes. (☞ Go to Question 6-1) ☐ No.

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

☐ No ☐ 1 to 2 days per month ☐ 3 to 9 days per month

☐ 10 to 29 days per month ☐ Every day

[Drinking] ※ In the past one year

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

☐ times per week ☐ times per month ☐ times per year

☐ I don' t drink alcohol

_____ time

hundred	0	1	2	3	4	5	6	7	8	9
tens	0	1	2	3	4	5	6	7	8	9
ones	0	1	2	3	4	5	6	7	8	9

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

☐ Soju ☐ Beer ☐ Hard liquor

☐ Makgeolli (Rice wine) ☐ Wine

Glass	Bottle	Can	cc

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

☐ Soju ☐ Beer ☐ Hard liquor

☐ Makgeolli (Rice wine) ☐ Wine

Glass	Bottle	Can	cc

※ Make sure that the writing is thick and accurate in the check box ( ) with a black pen (ex : ☑ ■ ◙ ☒)

[Exercising]

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

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

☐0 day ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

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

____ time	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23
____ minute	☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50 ☐55

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

☐0 day ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

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

____ time	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 ☐13 ☐14 ☐15 ☐16 ☐17 ☐18 ☐19 ☐20 ☐21 ☐22 ☐23
____ minute	☐0 ☐5 ☐10 ☐15 ☐20 ☐25 ☐30 ☐35 ☐40 ☐45 ☐50 ☐55

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?

☐0 day ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days

Additional health checkup questionnaires

Functional assessment of elderly ※ 66, 70, 80 years of age

1. Do you receive inoculations with influenza vaccine every year? ☐ Yes ☐ No
2. Have you received vaccinations against pneumonia? ☐ Yes ☐ No
3. The following questions are about your ability to perform activities of daily living. Please read and answer the questions below.

Question	Answer
1) If someone sets the table for your meal, you can eat by yourself without any help.	☐ Yes ☐ No
2) Can you put on your clothes without any help?	☐ Yes ☐ No
3) Can you go to the toilet by yourself?	☐ Yes ☐ No
4) When you take a bath or a shower, can you wash by yourself?	☐ Yes ☐ No
5) Can you prepare your meals?	☐ Yes ☐ No
6) Can you go to places that are of walking distance, such as a store, clinic, neighbor, or any public offices, by yourself?	☐ Yes ☐ No

4. About fall injury: Have you fell down during the last 6 months? ☐ Yes ☐ No
5. Urinary function: Do you have any difficulty in urinating or in holding your urine? ☐ Yes ☐ No

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.

※ 20, 30, 40, 50, 60, 70 years of age

How often have you suffered from the following symptoms over the past two weeks?	Not at all (0)	For a few days (1)	For over a week (2)	Almost every day (3)
1. I am barely interested in my work.	☐	☐	☐	☐
2. I feel melancholy, depressed, or hopeless.	☐	☐	☐	☐
3. It is hard to fall asleep or I wake up very often during the night, or I sleep too much.	☐	☐	☐	☐
4. I feel exhausted or have no energy.	☐	☐	☐	☐
5. I have low appetite or eat too much.	☐	☐	☐	☐
6. I think that I am a bad person or a failure, or I feel like my family is unhappy because of me.	☐	☐	☐	☐
7. I cannot concentrate when I read a newspaper or watch TV.	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. I think I am better off dying, or I want to hurt myself in some way.	☐	☐	☐	☐
Points	/ 27			

National Cancer Screening Program

※ Make sure that the writing is thick and accurate in the check box ( ) with a black pen (ex : ☑ ■ ▣ ☒)

Make sure to mark the inside of the check box.

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?

☐ Yes (symptom:) ☐ No

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

☐ No

☐ weight loss ➡ ☐ 5kg ☐ 6kg ☐ 7kg ☐ 8kg ☐ 9kg ☐ Over 10 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	Between1 and 2 years	Between 2 and 10 years
Gastric Cancer	Photography	☐	☐	☐	☐
	Endoscopy	☐	☐	☐	☐
Breast Cancer	Mammogram	☐	☐	☐	☐
Colon and Rectal Cancer	Fecal Occult Blood (Stool Test)	☐	☐	☐	☐
	Barium Enema	☐	☐	☐	☐
	Endoscopy	☐	☐	☐	☐
Cervical Cancer	Cervical Skin Exam	☐	☐	☐	☐
Hepatoma	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.

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

Disease	Yes	Disease	Yes	Disease	Yes
Gastric ulcer	☐	atrophic gastritis	☐	intestinal metaplasia	☐
Polyp	☐	others	☐	None	☐

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

Disease	Yes	Disease	Yes	Disease	Yes
Polyp–rectal	☐	Ulcerative colitis	☐	Crohn' s disease	☐
Hemorrhoid	☐	Other	☐	None	☐

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

Disease	Yes	Disease	Yes	Disease	Yes
Hepatitis B carrier	☐	Hepatitis B	☐	Hepatitis C	☐
Cirrhosis	☐	Others	☐	None	☐

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

1. When was your first menstrual period? ⬇ ☐ I have not gotten my period yet.

Start age ____age		0	1	2	3	4	5	6	7	8	9
	ten digit	0	1	2	3	4	5	6	7	8	9
	units digit	0	1	2	3	4	5	6	7	8	9

2. Do you still experience menstrual periods?

☐ Yes ☐ I have remove my cervix or uterus ☐ Menopause ⬇

Menopause ____age		0	1	2	3	4	5	6	7	8	9
	ten digit	0	1	2	3	4	5	6	7	8	9
	units digit	0	1	2	3	4	5	6	7	8	9

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

☐ Never ☐ Yes; for less than 2 years ☐ Yes; for a period between 2 and 5 years

☐ Yes; for more than 5 years ☐ No idea

4. How many children do you have?

☐ 1 ☐ More than 2 ☐ No child

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

☐ Less than 6 months ☐ Between 6 and 12 months

☐ More than 1 year ☐ Not applicable

6. 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.)

☐ Yes ☐ No ☐ No idea

7. Have you taken any birth control pills?

☐ Never ☐ Less than 1 year ☐ Over 1 year

☐ No idea

Dental Health Screening Program

※ Make sure that the writing is thick and accurate in the check box ( ) with a black pen (ex : ☑ ■ ◘ ☒)

Make sure to mark the inside of the check box.

Day of examination			
Name		Gender	☐ male ☐ female
Date of birth			
Phone No.			

[Barcode]

[These are questions about your dental history and awareness about your oral health]

1. Have you visited a dental clinic during the last year?	☐ Yes ☐ No
2. Do you have diabetes?	☐ Yes ☐ No ☐ No idea
3. Do you have cardiovascular disease(s)?	☐ Yes ☐ No ☐ No idea
4. Do you have any difficulties in chewing food because of your teeth, gums, or dentures for the last 3 months?	☐ Yes ☐ No
5. Have you had a toothache or soreness for the last 3 months?	☐ Yes ☐ No
6. Have you had any pain or bleeding in your gums?	☐ Yes ☐ No
7. How do you describe your oral health, including your teeth and gums?	☐ Excellent ☐ Good ☐ Normal ☐ Not well ☐ Never been worse

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

9. Have you learned how to brush teeth from a dental clinic or health center?	☐ Yes ☐ No
10. How many times did you brush your teeth yesterday?	☐ Once ☐ Twice ☐ 3 times ☐ 4 times ☐ 5 times

11. How often did you brush your teeth before going to bed during the last week?

☐ Every day (7 times) ☐ Almost every day (4~6 times) ☐ Occasionally (1~3 times) ☐ Never (0 times)

12. How often did you use dental floss or floss brush during the last week?

☐ Every day ☐ Almost every day ☐ Occasionally ☐ Never ☐ I do not know what a dental floss or floss brush is.

13. Does your toothpaste contain fluoride?	☐ Yes ☐ No ☐ I do not know
14. How many times do you consume sweets or sticky snacks, such as cookies, candies, and cakes, per day?	☐ Never ☐ Once ☐ 2~3 times ☐ More than 4 times ☐ I do not know
15. How many times do you drink soda or sweet drinks (including sports drink, ion supply drinks, and fruit juices)?	☐ Never ☐ Once ☐ 2~3 times ☐ More than 4 times ☐ I do not know
16. Do you smoke?	☐ Never smoked ☐ Currently smoke ☐ 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.