

Training Completion Certificate Number:										검진일자		
<div>■ 특수 □ 일반</div> <div>□ 배치전 □ 의료급여생애전환기</div>										차트번호		
출장	원내	뇌심	직무	이상지질	B형간염	C형간염	골밀도	생활습관	인지기능	정신건강	노인신체	
※ Please be sure to check all yellow highlighted sections on the front and back.								※ Please enter your information accurately for result SMS delivery.				
Name		Resident Registration Number			Mobile Phone							
Workplace Name									Daily Working Hours		8 hours	
Department Name		Job Description			Date of Joining			현장투입일				
Past Work History	Job Description		Years Worked		Period		진동	악력	좌		우	
								진동각	□ 이상없음 □ 이상소견:			
								통각	□ 이상없음 □ 이상소견:			
								손톱압박	□ 2초 이내 □ 2초 초과			
유해인자	소음, 광물성분진, 자외선								사전조사			
검사항목	□ 폐활량											
■ 신 장		□ 본인기재				■ 현재증상		□ 무 □ 유:				
■ 체 중		□ 본인기재				■ 과거증상		①무 ①뇌졸중 ②심장병 ③고혈압 ④당뇨병 ⑤이상지질 ⑥폐결핵 ⑦기타:				
허리둘레		□ 본인기재				■ 가 족 력		①무 ①뇌졸중 ②심장병 ③고혈압 ④당뇨병 ⑤기타:				
시력 (좌/우)		/		□ 교 정		생활습관		①금연필요 ②절주필요 ③신체활동필요 ④근력운동필요				
청력 (좌/우)		/		□ 보 청 기		■ 업무기인성		□ 무 □ 유:				
■ 혈 압		/		/		신 경 계		□ 이상없음 □ 이상소견:				
■ 흉부방사선						심혈관계		□ 이상없음 □ 이상소견:				
요 단 백		생 리 □ 무 □ 유				위장관계		□ 이상없음 □ 이상소견:				
골 밀 도						내분비계		□ 이상없음 □ 이상소견:				
노인신체	하지기능	일어나서3m걸고돌아와았기			초		근골격계	□ 이상없음 □ 이상소견:				
	보행장애	□ 무 □ 유				금속열증상		□ 이상없음 □ 이상소견:				
	한발로 서기	눈감은상태			초		간담도계	□ 이상없음 □ 이상소견:				
눈뜬상태			초		■ 눈 · 피부 · 비강 · 인두	□ 이상없음 □ 이상소견:						
■ 기도순음청력검사						비뇨기계		□ 이상없음 □ 이상소견:				
500	1000	2000	3000	4000	6000	생 식 계		□ 이상없음 □ 이상소견:				
좌						악구강계		□ 이상없음 □ 이상소견:				
우						조혈기계		□ 이상없음 □ 이상소견:				
과좌						■ 호흡기계		□ 이상없음 □ 이상소견:				
과우						■ 청 진		□ 이상없음 □ 이상소견:				
검 사 자			(서명)			■ 이비인후계		□ 이상없음 □ 이상소견:				
Confirmation of Noise Exposure Interruption for 14 Hours or More			(Signature)			■ 이경 (좌/우)		/				
심 전 도			①정상 ②부정맥 ③심혈관 ④심비대 ⑤심장염 ⑥전해질 ⑦기타:			그 외 특이사항						
특수건강진단 문진의사	면허번호			일반건강검진 문진의사	면허번호			특수+일반 문진의사	면허번호			
	성 명	(서명)			성 명	(서명)			성 명	(서명)		

📖 Medical History (Past History)

1. Have you ever been diagnosed with or are you currently receiving medication for any of the following diseases?

None	Category	Stroke	Myocardial infarction / Angina	Hypertension	Diabetes	Dyslipidemia	Tuberculosis	Depression	Early psychosis	Chronic Obstructive Pulmonary Disease (COPD)	Hepatitis C	Others (including cancer)
	Diagnosis:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
	Medication treatment:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

2. (Family History) Have any of your parents, brothers, or sisters had the following diseases or died from them?

None	Stroke	Myocardial infarction / Angina	Hypertension	Diabetes	Others (including cancer)
<input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes

3. Are you a carrier of Hepatitis B virus?

(※ A carrier refers to a chronic Hepatitis B infection.)

- ① Yes ② No ③ Do not know

🚬 Smoking & Electronic Cigarettes

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

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

4-1. Do you currently smoke cigarettes?

① Currently smoking	Total__years	Average _____ cigarettes per day	
② Smoked in the past but quit	Total__years	Average _____ cigarettes per day	Quit____years ago

5. Have you ever used heated tobacco products (e.g., IQOS, Glo, Lil)?

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

5-1. Do you currently use heated tobacco products?

① Currently using	Total__years	Average _____ sticks per day	
② Used in the past but not currently	Total__years	Average _____ sticks per day when using	Quit____years ago

6. Have you ever used liquid-type electronic cigarettes (vapes)?

- ① No ② Yes (➡ Go to Question 6-1)

6-1. In the past month, how often did you use liquid-type e-cigarettes?

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



※ During the past 1 year

7. How often do you drink alcohol? (Choose one)

- ① () times per week ② () times per month
③ () times per year ④ I do not drink alcohol

7-1. On days when you drink, how much do you usually drink?

* Please fill in only one unit: glass, bottle, can, or cc (ml).

(Multiple types of alcohol can be selected. Calculate the total amount consumed in one day.)

Type of alcohol	Glass	Bottle	Can	cc
Soju				
Beer				
Liquor (spirits)				
Makgeolli (rice wine)				
Wine				

7-2. What is the largest amount of alcohol you have consumed in one day?

* Please fill in only one unit: glass, bottle, can, or cc (ml).

(Multiple types of alcohol can be selected. Calculate the total amount consumed in one day.)

Type of alcohol	Glass	Bottle	Can	cc
Soju				
Beer				
Liquor (spirits)				
Makgeolli (rice wine)				
Wine				



Physical Activity (Exercise)

8-1. During a typical week, on how many days do you perform vigorous physical activities that make you breathe much harder?

() days

* Examples: running, aerobics, fast cycling, construction work, carrying heavy items upstairs, etc.

8-2. On a typical day, how many hours do you perform vigorous physical activities?

() hours () mins

9-1. During a typical week, on how many days do you perform moderate physical activities that make you breathe slightly harder?

() days

* Do not include activities mentioned in Question 8.

* Examples: brisk walking, doubles tennis, normal-speed cycling, carrying light objects, cleaning, etc.

9-2. On a typical day, how many hours do you perform moderate physical activities?

() hours () mins

10. During the past week, on how many days did you perform muscle-strengthening exercises such as push-ups, sit-ups, dumbbells, barbells, or pull-ups? () days

For special health examination subjects only



Symptom checklist by target organ.

11. Please answer about any symptoms you have experienced during the past 6 months.

Body Part	Symptom	Symptoms			Body Part	Symptom	Symptoms		
		Severe	Mild	None			Severe	Mild	None
General	Loss of appetite and weight loss				Respiratory	Heart beats fast during work			
	Often feels fatigued					Cough and shortness of breath during work			
	Lump felt in some part of the body					Chest feels tight			
Skin	Skin is itchy or inflamed					Cough or phlegm in the morning after waking up			
	Spots appear on the skin					Cough when returning to work after resting			
	Changes in body hair, nails or toenails				Limb	Arms, legs or shoulders ache or hurt			
	Skin becomes rough or cracked					Hands or feet tremble or feel weak			
Eye	Eyes feel sore or watery					Numbness in hands or feet			
	Vision has worsened					Fingers turn white when cold			
	Eyes are red or painful				Nervous	Lower back pain			
Ear	Cannot hear speech clearly					Headache			
	Ringing in the ears					Dizziness			
Nose	Frequent nosebleeds					Memory decline or severe forgetfulness			
	Runny or stuffy nose					Anxiety or nervousness			
	Reduced sense of smell					Feeling dazed or drunk			
Mouth	Gums bleed or swell				Urinary / Reproductive	Difficulty concentrating			
	Taste is reduced					Difficulty urinating			
Digestive	Have had severe stomach pain					Body swelling			
	Strange bitter taste in the mouth					Irregular menstruation (Women only)			
	Constipation					History of miscarriage (Women only)			

If you have any other symptoms, please describe them in the space below.

* Have you ever experienced health problems (physical abnormalities) while working? ☐ Yes ☐ No

* Do you think your health problems were caused by substances handled during work? ☐ Yes ☐ No

Physician's
comments

* Please be sure to check all the yellow highlighted sections.

폐활량 검사 문진표

*폐기능 검사는 각종 분진, 중금속, 유기화합물에 노출되는 근로자의 폐의 기능을 측정하기 위한 노력성 폐활량 검사로 검사결과에 따라 최소 3회 ~ 최대 8회 실시하며 수검자의 협조가 절대적으로 필요합니다.

사업장명					
Name				Date of Birth	
Experience with Pulmonary Function Test	<input type="checkbox"/> Yes <input type="checkbox"/> No	Height:	cm	Weight:	kg
Use of Protective Equipment	<input type="checkbox"/> Not used <input type="checkbox"/> Dust mask <input type="checkbox"/> Gas mask				
Past or Current Diseases	<input type="checkbox"/> None <input type="checkbox"/> Severe cold <input type="checkbox"/> Pneumoconiosis <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Bronchitis <input type="checkbox"/> Ear disease <input type="checkbox"/> Heart disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hypertension <input type="checkbox"/> Other ()				
Surgical History	<input type="checkbox"/> None <input type="checkbox"/> Chest <input type="checkbox"/> Eye <input type="checkbox"/> Neck <input type="checkbox"/> Abdomen <input type="checkbox"/> Heart <input type="checkbox"/> Other ()				
Current Medication	<input type="checkbox"/> None <input type="checkbox"/> Bronchodilator (asthma, cold, etc.) <input type="checkbox"/> Blood pressure <input type="checkbox"/> Other ()				
Smoking History	<input type="checkbox"/> Never smoked <input type="checkbox"/> Former smoker, now quit <input type="checkbox"/> Currently smoking				
Denture Use	<input type="checkbox"/> None <input type="checkbox"/> Fixed (implant) <input type="checkbox"/> Removable (denture)				
Degree of Breathlessness	<input type="checkbox"/> Grade 0 : No breathlessness during normal daily activities; breathlessness occurs only with exercise Similar to people of the same age, height, and gender within normal range. <input type="checkbox"/> Grade 1 : More breathless than others of the same age when walking slowly on flat ground or climbing 1-2 flights of stairs. <input type="checkbox"/> Grade 2 : More breathless than others of the same age when walking on flat ground; difficulty walking together. <input type="checkbox"/> Grade 3 : Breathless when walking on flat ground or doing housework. <input type="checkbox"/> Grade 4 : Breathless even during simple activities such as dressing, talking, or moving from one room to another.				
금기사항(최근3개월 이내)		상대적 금기사항		당일 혈압	
심장질환, 뇌졸중 기흉, 대동맥류, 개복술 호흡기 감염질환 (결핵, 객혈 등)		흉부 및 복부통증, 구강 및 안면통증, 복압요실금 치매 및 의식의저하 2주이내 임플란트시술		<input type="checkbox"/> 검사 기능 <input type="checkbox"/> 검사 불가능 (*기준 180 / 110 이상)	
금기사항에 대한 의사소견					
* 검사자 의견 (아래의 내용은 폐활량 검사자가 직접 작성해 주십시오)					
취급 유해인자	<input type="checkbox"/> 기타광물성분진 <input type="checkbox"/> 용접흠 <input type="checkbox"/> 목재분진 <input type="checkbox"/> 산화철 <input type="checkbox"/> 기타()				
금일 흡연여부	<input type="checkbox"/> 무 <input type="checkbox"/> 1시간 경과 <input type="checkbox"/> 1시간내		검시기 종류	Spirometer HI-801()	
검 사 자 세	<input type="checkbox"/> 선자세 <input type="checkbox"/> 앉은자세		검사협조	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3	
기타의견					
검 사 일 시	년 월 일		검사자	(서명)	

Resident Registration Number: