Examination & Agreement Form 【Copy for Municipality】

for Cervical Cancer Screenings Provided by Local Municipalities in Shiga

If you wish to be screened for cervical cancer, please read the attached information sheet first.
After confirming the acknowledgement of personal information handling and your eligibility status, as well as acknowledging your responsibility for the examination fee if you are deemed ineligible for the screening but choose to still undergo it, please complete the following form with a ballpoint pen.

ID		Medical Institution Name		Date of Examination	
Examination Number		Furigana / Full Name		Method of Payment	1. Out-of-pocket payment 2. Exempted Household 3. Free Coupon 4. Other ( )
Address	〒 － (TEL － －) City・Town **※Please enter the address you have registered with your city/town**			Date of Birth	____ Year ___ Month ___ Date ____ years old

1. Have you undergone an examination for cervical cancer before?	● No (This includes those whose last examination was over 4 years ago) ● Yes (1 year ago・2 years ago・3 years ago) ● Unsure
2. What was the result of the examination?	● I was not told to undergo a thorough examination ● I was told to undergo a thorough examination (Year : _____) (Result : _____) ● Other ( )
3. Have you ever received a vaccination for cervical cancer prevention?	● No ● Yes → If so, when did you take it: (Year : _____) / (Unsure) How many doses of the vaccine did you take? (1 dose ・ 2 doses ・ 3 doses ・ Unsure)
4. About your recent menstrual cycle	No issues ・ Issues (Explain:) When was your last cycle: From ____ (Month) ____ (Day), for ____ days long Menopause (at ____ years old) ・ Currently Pregnant ・ Just given birth or miscarriage (How many months ago: ___)
5. About sexual activity and childbirth	Have you had sexual intercourse? (Yes・No) How many times have you been pregnant? (___ times) How many times have you given childbirth? (___ times) → Have you had a C-section? (Yes ____ times ・ No)
6. Have you previously had cancer?	● No ● Yes (In which body part:)
7. Are you currently taking any of the following types of medication?	No Yes (IUD・Contraceptive Pill・Hormone Drug) For how many years? ___ years → Are you regularly undergoing checkups for this medication? (Yes・No)
8. Have you undergone any of the procedures (such as surgery) listed on the right?	No Yes → Uterine Surgery ( ) Ovarian Surgery ( ) Are you still under observation after the surgery? (Yes・No)
9. Have you experienced any of the following symptoms in the past 6 months?	No Yes → Continued bleeding after menopause・Bleeding not caused by menstruation・Heavy menstrual flow Bleeding on contact caused by sexual intercourse・Brown discharge・Pink discharge