[Annex No. 1] <Front>

National Screening Program

□ Regular checkup □ Life cycle-based checkup

※ Answers must be provided for all questions so the information will be reported correctly.

First Name		Residential ID No.		Telephone	Home	
Given Name					Mobile phone	
Current address					Zip code	-
					E-mail	

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

※ These are questions about your medical history.

※ Please answer the following questions about your present condition by ticking the appropriate box.

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

Disease	Brain stroke / paralysis	Heart disease (cardiac infarction / angina)	High blood pressure	Diabetes	Dyslipidemia	Tuberculosis	Others (including cancer)
a							
b							

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

Disease	Brain stroke / paralysis	Heart disease (cardiac infarction / angina)	High blood pressure	Diabetes	Others (including cancer)
Yes					

3. Are you a Hepatitis B virus antigen carrier? ① Yes ② No ③ No idea

※ These are questions about smoking.

4. Please answer the following questions about your present condition by ticking the appropriate box.

4-1. Have you ever smoked over 5 packs of tobacco (100 cigarettes) in your life?

① No, I never smoked. (☞ Go to Question 5) ② Yes, I used to smoke but I stopped. (☞ Go to Question 4-2)

③ Yes, I'm still smoking (☞ Go to Question 4-3)

4-2. If you used to smoke but stopped, please answer the following.

For how many years had you smoked?	Total_____years
How many cigarettes in a typical day did you smoke before you stopped?	_____cigarettes

4-3. If you are still smoking, please answer the following.

How long have you been smoking?	Total_____years
How many cigarettes on average do you smoke on a regular day?	_____cigarettes

※ These are questions about drinking.

5. Please answer the following questions about your current drinking habit by ticking the appropriate box.

5-1. How many times a week do you drink alcohol?

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

5-2. When you drink, how much do you usually drink on a regular day? (glass(es))

(※ No matter what kind of liquor it may be, each glass will be considered as 1 glass. However, 1 can of beer (355 cc) is equal to 1.6 glasses of beer.)

[Annex No. 1] <Back>

※ These are questions about exercising.

6. These are questions about your physical activity for the last week. Please answer the following questions by ticking the appropriate box.

6-1. During the last week, how many days did you exercise vigorously for over 20 minutes until you were almost out of breath? (example: running, aerobics, high-speed cycling, mountain hiking, etc.)

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

6-2. During the last week, how many days did you exercise in a moderate level for more than 30 minutes until you had to breathe a little faster than usual? (example: fast walking, tennis, bicycle riding, cleaning, etc.) ※ Except the relevant answer from 6-1

□ 0 □ 1 □ 2 □3 □ 4 □ 5 □ 6 □ 7

6-3. During the last week, how many days did you walk for a total of 30 minutes or more in a day, including separate 10-minute walks? (example: light exercise, walk for work or for leisure, etc.)

※ Please exclude exercises you answered in 6-1 and 6-2

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

※ **These are questions about cognitive functions. (Only answer if you are 66, 70, or 74 years old.)** (If a family member accompanied you, please let him/her answer the questions. If not, answer the following questions by yourself.)

7. Please answer the following questions about your current cognitive condition compared to last year by ticking the appropriate box.

7-1. Compared to friends or other people, your memory is worse than others.

① No ② Occasionally ③ Yes

7-2. Your memory is worse compared to last year.

① No ② Occasionally ③ Yes

7-3. You experience problems related to your memory when handling important matters.

① No ② Occasionally ③ Yes

7-4. Has anyone noticed that you have a short memory?

① No ② Occasionally ③ Yes

7-5. Do you experience difficulties in performing daily chores that you used to do well before?

① No ② Occasionally ③ Yes

※ Emotional status (Only answer if you are 40 years old.)

8. Please identify how many times you experienced the following during the last week by ticking the appropriate box.

During the last week, I	Hardly ever (less than 1 day)	Not too often (couple of days)	Sometimes (more than 3 days)	Always (over 5 days)
8-1. Was annoyed and bothered by things that were not there before.				
8-2. Did not want to eat and even lost appetite.				
8-3. Felt sad even when someone tried to help me out.				
8-4. Felt depressed.				

※ Please complete this form with Annex No. 2 only 66 years old.

[Annex No. 2] <Front>

Supplementary Medical Screening Program for Those Aged 66

Fist Name		Residential ID No.		Telephone	Home	
Given Name					Mobile phone	
Current address					Zip code	-
					E-mail	

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

※ These are questions about inoculations.

1. Do you receive inoculations with influenza vaccine every year? ① Yes ② No

※ These are questions about your capabilities on daily routines.

2. Please answer the following questions about your present condition by ticking the appropriate box.

2-1. If someone sets the table for your meal, you can eat by yourself without any help.
① Yes ② No

2-2. Can you put on your clothes without any help?
① Yes ② No

2-3. Can you go to the toilet by yourself?
① Yes ② No

2-4. When you take a bath or a shower, can you wash by yourself?
① Yes ② No

2-5. Can you prepare your meals?
① Yes ② No

2-6. Can you go to places that are of walking distance, such as a store, clinic, neighbor, or any public offices, by yourself?
① Yes ② No

[Annex No. 2] <Back>

※ These are questions about affective status.

3. Please answer the following questions about your present condition by ticking the appropriate box.

3-1. Have you become less active and have little will to do anything lately?

① Yes ② No

3-2. Do you feel you are useless?

① Yes ② No

3-3. Do you feel that your future is hopeless?

① Yes ② No

※ These are questions about fall injury and urinary function.

4. About fall injury: Have you fell down during the last 6 months?

① Yes ② No

5. Urinary function: Do you have any difficulty in urinating or in holding your urine?

① Yes ② No

[Annex No. 3]

Dental Health Screening Program

□ Regular checkup □ Life cycle-based checkup

First Name		Residential ID No.		Telephone	Home	
Given Name					Mobile phone	
Current address					Zip code	-
					E-mail	

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

※ 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.

[Annex No. 1] <Front>

National Cancer Screening Program

□ **Regular checkup** □ **Life cycle-based checkup**

Fist Name		Residential ID No.		Telephone	Home	
Given Name					Mobile phone	
□ Health insurance □ Medicaid recipient			E-mail			
Current address					Zip code	
					-	

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

※ 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?
   ① Yes (symptom:_____) ② No

2. **In the last 6 months, have you experienced a weight increase exceeding 5 kg without any specific reason**?
   ① No ② Yes; total weight loss (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	Between 1 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

[Annex No. 1] <Back>

※ These are questions only about gastric cancer, hepatoma, and colon and rectal cancer.

※ Please answer the following questions about your present condition by ticking the appropriate box.

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

Disease	Gastric ulcer	Gastritis	Duodenal ulcer	Polyp	Others (write)	None
Yes						

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

Disease	Polyp—rectal	Ulcerative colitis	Crohn's disease	Hemorrhoid	Others (write)	None
Yes						

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

Disease	Hepatitis B carrier	Hepatitis B	Hepatitis C	Cirrhosis	Others (write)	None
Yes						

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

8. When was your first menstrual period?

① Age _____ ② I have not gotten my period yet.

9. Do you still experience menstrual periods?

① Yes ② I have remove my cervix or uterus

③ Menopause (age:_____)

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

① Never ② Yes; for less than 2 years

③ Yes; for a period between 2 and 5 years ④ Yes; for more than 5 years ⑤ No idea

11. How many children do you have?

① 1 ② More than 2 ③ No child

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

① Less than 6 months ② Between 6 and 12 months ③ More than 1 year ④ Not applicable

13. 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.)

① Yes ② No ③ No idea

14. Have you taken any birth control pills?

① Never ② Less than 1 year

③ Over 1 year ④ No idea

[Annex No. 7] <Page 1>

Results of Regular Medical Checkup (1st)

Subject name		Resident registration number	-	Health checkup institution	☐Visit, ☐on-site checkup	examination

What is a general health checkup?

It is a nationwide health checkup carried out to detect chronic illnesses, such as hypertension, diabetes, etc., in accordance with the National Health Insurance Act and the Medical Care Assistance Act.
After the health checkup, we refer you to the appropriate treatment if required and help you to prevent diseases, such as cardiovascular and cerebrovascular diseases and so on, in advance by providing information on how to maintain a healthy life.

How is the general impression of my checkup result?

Determination - ☐ Normal A ☐ Normal B ☐ General disease ☐Hypertension or diabetes mellitus suspected ☐ Abnormal ( )

- **Mr./Mrs./Ms. , you need to take immediate actions for the following details.**

- **Mr./Mrs./Ms. , you need to have great focus to manage the following details.**

How is the result of my major health status?

	Body Mass Index (BMI) (kg/㎡)	Blood pressure (Systolic/Diastolic,mmHg)	Blood sugar (mg/dl)	LDL Cholesterol (mg/dl)
Danger				
Borderline				
Normal				

	Physical activity	Alcohol consumption	Smoking
Danger			
Borderline			
Normal			

Year of 2009 Year of 2011 (your data regarding physical activity, alcohol consumption, and smoking are based on the questionnaire you have answered.)

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How is the result of my major health status?

* Figures written in the boxes are your the result values of your health checkup.

* Blood test result may vary according to the reference criteria used by each health checkup institution in the determination of normal A, normal B, and suspected disease.

Test type	Objective disease	Examination item	Examination result
Measuring examination	Obesity	Height/weight (cm/kg)	/
		waist (cm)	Normal A: Male 90, Female 85 / Disease suspected
		BMI (kg/㎡)	Normal B: 18.5 / Normal A: 25 / Normal B: 30 / Disease suspected
	Hypertension	Systolic blood pressure (mmHg)	Normal A: 120 / Normal B: 140 / Disease suspected
		Diastolic blood pressure (mmHg)	Normal A: 80 / Normal B: 90 / Disease suspected
	Abnormality of visual acuity, auditory acuity	Visual acuity (left/right)	/ ☐ corrected / Auditory acuity (left/right) /
Blood test	Anemia	Hemoglobin (g/dL)	Normal A / Normal B / Disease suspected ( ) ( ) ( )
	Diabetes Mellitus	Fasting blood sugar	Normal A / Normal B / Disease suspected ( ) ( )
	Dyslipidemia	Total cholesterol (mg/dL)	Normal A / Normal B / Disease suspected ( ) ( )
		HDL cholesterol (mg/dL)	Normal A / Normal B / Disease suspected ( ) ( )
		Triglyceride (mg/dL)	Normal A / Normal B / Disease suspected ( ) ( )
		LDL cholesterol (mg/dL)	Normal A / Normal B / Disease suspected ( ) ( )
	Kidney disease	Serum creatinine (mg/dL)	Normal A / Disease suspected ( )
		Glomerular filtration rate (e-GFR) (mL/min/1.73 ㎡)	Normal A / Disease suspected ( )
	Liver disease	AST(SGOT)(U/L)	Normal A / Normal B / Disease suspected ( ) ( )
		ALT(SGPT)(U/L)	Normal A / Normal B / Disease suspected ( ) ( )
		Gamma-GTP(γ-GTP)(U/L)	Normal A / Normal B / Disease suspected ( ) ( ) ( )
Urinalysis	Kidney disease	Proteinuria	
Image	Pulmonary tuberculosis / thoracic disease	Chest X-ray	

Physical examination (questionnaire)				
	Past medical history diagnosis		Medication therapy	
	Lifestyle		Trauma and sequela	
	General status		Depression test	

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Health risk evaluation result

Specific health risk for each disease
Knowing your health risk factors
Controlling your health risk factors

※ A health risk evaluation is carried out to induce improved behavior toward health from subjects to reduce health risks by predicting possible diseases they may have and their future health status through the analysis of the subjects' health risk factors based on the questionnaire completed by the subjects and their checkup result.

We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above

. .

Determination date	Examined doctor	License (Qualification) number	Name	(signature)
			(Medical institution number)	

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.

[Annex No. 8] <Page 1>

Results of Regular Medical Checkup (2nd)

Subject name	Resident registration number	-	Health checkup institution	☐Visit, ☐on-site checkup	examination

How is the general impression of my checkup result??

- **Mr./Mrs./Ms. , you need to take immediate actions for the following details.**

- **Mr./Mrs./Ms. , you need to have great focus to manage the following details.**

How is my health checkup result?

Diabetes mellitus	Fasting blood sugar _____mg/dl	☐ Normal Less than 100	☐ Fasting blood sugar disorder 100-125	☐ Diabetes mellitus Greater than 126
Hypertension	Systolic _____mmHg Diastolic _____mmHg	☐ Normal a systolic level of less than 120 and a diastolic level of less than 80	☐ Pre-stage of hypertension a systolic level of 120−139 or a diastolic level of 80−89	☐ Hypertension A systolic level greater than 140 or a diastolic level greater than 90
Cognitive function disorder (70 and 74 years old)	_____points	☐ No specific abnormality (0−5 points)	☐ Declined cognitive function (6−30 points; additional examination and consultation required)	

We notify your general health checkup result (second examination) as above.

. .

Determination date	Examined doctor	License (Qualification) number	Name	(signature)

(Medical institution number)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.

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Chronic illness and improvement of lifestyle

"Disease information related to the objective disease"

[Annex No. 9] <Page 1>

Results of Life Cycle–Based Medical Checkup (1st, 40 Years Old Only)

Subject name	Resident registration number	-	Health checkup institution	☐Visit, ☐on-site checkup examination

What is a health checkup for the lifetime transition period?

It is a national health checkup(provided for the National Health Insurance Act and the Medical Care Assistance Act) in consideration of sex and age specifications, which consist of general health checkup categories, such as hypertension, diabetes mellitus, etc., and categories required in the health checkup for the lifetime transition period (age of 40, 66), such as bone density test, geriatric physical function test, mental health test, cognitive disorder test, dental plaque test, lifestyle evaluation, etc.

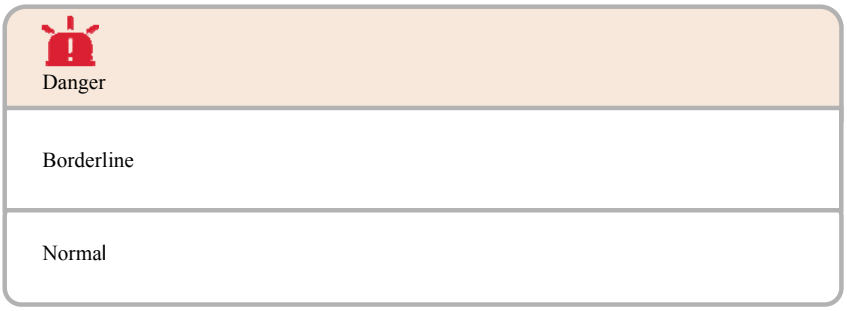
How is the general impression of my checkup result?

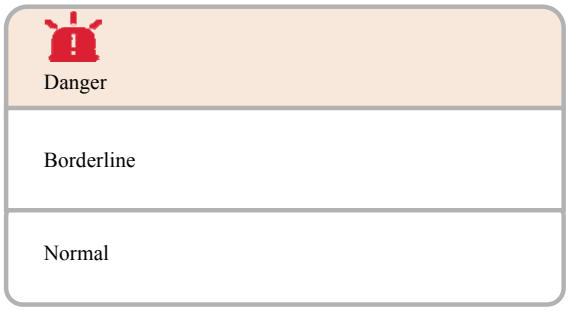
Determination - ☐ Normal A ☐ Normal B ☐ General disease ☐Hypertension or diabetes mellitus suspected ☐ Abnormal ( )

- **Mr./Mrs./Ms. , you need to take immediate actions for the following details.**

- **Mr./Mrs./Ms. , you need to have great focus to manage the following details.**

How is the result of my major health status?





Year of 2009 Year of 2011 (your data regarding physical activity, alcohol consumption, and smoking are based on the questionnaire you have answered.)

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How is the result of my major health status?

* Figures written in the boxes are your the result values of your health checkup.

* Blood test result may vary according to the reference criteria used by each health checkup institution in the determination of normal A, normal B, and suspected disease.

Test type	Objective disease	Examination item	Examination result
Measuring examination	Obesity	Height/weight (cm/kg)	/
		Waist (cm)	Normal A: Male 90, Female 85 / Disease suspected
		BMI (kg/㎡)	Normal B: 18.5 / Normal A: 25 / Normal B: 30 / Disease suspected
	Hypertension	Systolic blood pressure (mmHg)	Normal A: 120 / Normal B: 140 / Disease suspected
		Diastolic blood pressure (mmHg)	Normal A: 80 / Normal B: 90 / Disease suspected
	Abnormality of visual acuity, auditory acuity	Visual acuity (left/right)	/ ☐ corrected / Auditory acuity (left/right) /
Blood test	Anemia	Hemoglobin (g/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Diabetes mellitus	Fasting blood sugar	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Dyslipidemia	Total cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		HDL cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		Triglyceride	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		LDL cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Kidney disease	Serum creatinine (mg/dL)	Normal A ( ) / Disease suspected ( )
		Glomerular filtration rate (e-GFR)(mL/min/1.73m²)	Normal A ( ) / Disease suspected ( )
	Liver disease	AST(SGOT)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		ALT(SGPT)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		Gamma-GTP (γ-GTP)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		Hepatitis B	Surface antigen (infection source): ☐ Normal ☐ In-depth( )
			Surface antibody (immune system): ☐ Normal ☐ In-depth( )
			Examination result: ☐ Hepatitis carrier ☐ Immune ☐ Subject for vaccination
Urinalysis	Kidney disease	Proteinuria	
Image	Pulmonary tuberculosis / thoracic disease	Chest X-ray	
Physical examination (questionnaire)	Past medical history diagnosis		Medication therapy
	Lifestyle		Trauma and sequela
	General status		Depression test

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Health risk evaluation result

Specific health risk for each disease
Knowing your health risk factors
Controlling your health risk factors

Result for lifestyle evaluation

We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above

. .

Determination date	Examined doctor	License (Qualification) number	Name	(signature)
			(Medical institution number)	

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..

[Annex No. 10] <Page 1>

Results of Life Cycle–based Medical Checkup (1st, 66 Years Old Only)

Subject name	Resident registration number	-	Health checkup institution	☐Visit, ☐on-site checkup	examination

What is a health checkup for the lifetime transition period?

It is a national health checkup(provided for the National Health Insurance Act and the Medical Care Assistance Act) in consideration of sex and age specifications, which consist of general health checkup categories, such as hypertension, diabetes mellitus, etc., and categories required in the health checkup for the lifetime transition period (age of 40, 66), such as bone density test, geriatric physical function test, mental health test, cognitive disorder test, dental plaque test, lifestyle evaluation, etc.

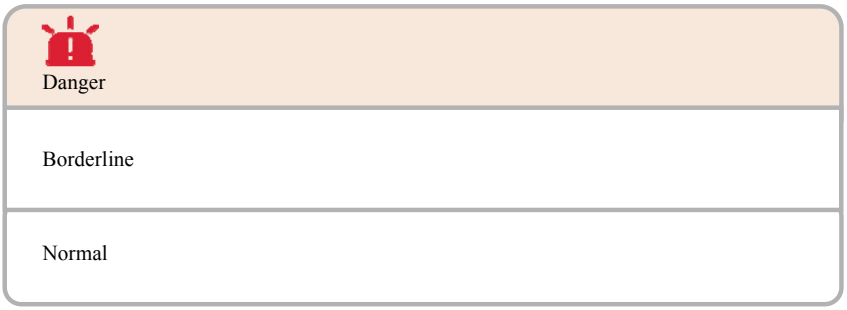
How is the general impression of my checkup result?

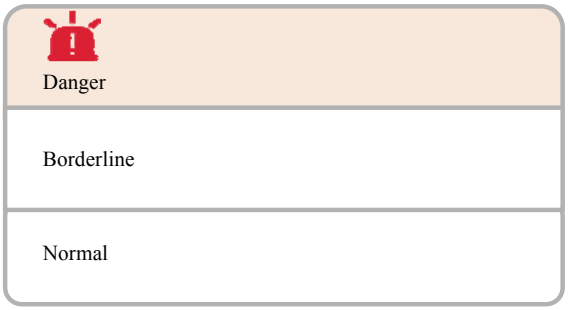
Determination - ☐ Normal A ☐ Normal B ☐ General disease ☐Hypertension or diabetes mellitus suspected ☐ Abnormal ( )

- **Mr./Mrs./Ms. , you need to take immediate actions for the following details.**

- **Mr./Mrs./Ms. , you need to have great focus to manage the following details.**

How is the result of my major health status?





Year of 2009 Year of 2011 (your data regarding physical activity, alcohol consumption, and smoking are based on the questionnaire you have answered.)

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How is the result of my major health status?

* Figures written in the boxes are your the result values of your health checkup..

* Blood test result may vary according to the reference criteria used by each health checkup institution in the determination of normal A, normal B, and suspected disease.

Test type	Objective disease	Examination item	Examination result
Measuring examination	Obesity	Height/weight (cm/kg)	/
		Waist (cm)	Normal A: Male 90, Female 85 / Disease suspected
		BMI (kg/㎡)	Normal B: 18.5 / Normal A: 25 / Normal B: 30 / Disease suspected
	Hypertension	Systolic blood pressure (mmHg)	Normal A: 120 / Normal B: 140 / Disease suspected
		Diastolic blood pressure (mmHg)	Normal A: 80 / Normal B: 90 / Disease suspected
	Abnormality of visual acuity, auditory acuity	Visual acuity (left/right)	/ ☐ corrected
		Auditory acuity (left/right)	/
Blood test	Anemia	Hemoglobin (g/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Diabetes Mellitus	Fasting blood sugar	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Dyslipidemia	Total cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		HDL cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		Triglyceride (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		LDL cholesterol (mg/dL)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
	Kidney disease	Serum creatinine (mg/dL)	Normal A ( ) / Disease suspected ( )
		Glomerular filtration rate (e-GFR) (mL/min/1.73 ㎡)	Normal A ( ) / Disease suspected ( )
	Liver disease	AST(SGOT)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		ALT(SGPT)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
		Gamma-GTP (γ-GTP)(U/L)	Normal A ( ) / Normal B ( ) / Disease suspected ( )
Urinalysis	Kidney disease	Proteinuria	
Image	Pulmonary tuberculosis / thoracic disease	Chest X-ray	
	Osteoporosis	Bone density test	
Geriatric physical function test	Fall	Lower extremity function	
		Balance	

Physical examination (questionnaire)					
	Past medical history diagnosis		Medication therapy		
	Lifestyle		Trauma and sequela		General status
	General status		Depression test		

210㎜×297㎜[백상지 80g/㎡]

Health risk evaluation result

Specific health risk for each disease

Knowing your health risk factors

Controlling your health risk factors

Results for disease prevention and evaluation of performance ability for daily life activities

- Flu vaccination ☐ Yes ☐ No
- Risk for falling (Whether to experience falling) ☐ Yes ☐ No
- Dysuria suspected ☐ Yes ☐ No
- Risk for osteoporosis (Female) ☐ Yes ☐ No
- Performance ability for everyday activities ☐ Normal ☐ Mild ☐ Moderate ☐ Severe

Result for evaluation of geriatric physical function

- Visual acuity ☐ Normal ☐ Loss of eyesight
- Auditory acuity ☐ Normal ☐ Loss of hearing
- Function test ☐ Normal ☐ Mild ☐ Severe

Result for lifestyle evaluation

※ You can receive specific details from a physician about the results of this 2nd test.

We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above

. .

Determination date | Examined doctor | License (Qualification) number | Name (signature)

(Medical institution number)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..

210㎜×297㎜[백상지 80g/㎡]

[Annex No. 11] <Page 1>

Results of 2nd Life Cycle–based Medical Checkup

Subject name	Resident registration number	-	Health checkup institution	☐Visit, ☐on-site checkup	examination

How is the general impression of my checkup result?

- **Mr./Mrs./Ms. , you need to take immediate actions for the following details.**

- **Mr./Mrs./Ms. , you need to have great focus to manage the following details.**

Summary of my 1st health checkup results

How is my health checkup result?

Diabetes mellitus	Fasting blood sugar _____mg/dl	☐ Normal Less than 100	☐ Fasting blood sugar disorder 100-125	☐ Diabetes mellitus Greater than 126
Hypertension	Systolic _____mmHg Diastolic _____mmHg	☐ Normal a systolic level of less than 120 and a diastolic level of less than 80	☐ Pre-stage of hypertension a systolic level of 120–139 or a diastolic level of 80–89	☐ Hypertension A systolic level greater than 140 or a diastolic level greater than 90
Cognitive function disorder (66 years old)	_____points	☐ No specific abnormality (0–5 points)	☐ Declined cognitive function (6-30 points; additional examination and consultation required)	
Depression (40 years old)	_____points	☐ No specific abnormality (0–20 points)	☐ Borderline (21–24 points)	☐ Depression suspected (25–60 points; additional examination and consultation required)
Depression (66 years old)	_____points	☐ No specific abnormality (0–90 points)	☐ Borderline (10–11 points)	☐ Depression suspected (12–15 points; additional examination and consultation required)

210㎜×297㎜[백상지 80g/㎡]

How is the result of my lifestyle evaluation?

Smoking

Evaluation Prescription

☐ Low (0–3 points) ☐ Middle (4–6 points) ☐ High (7–10 points)

☐ Consultation and education ☐ Nicotine replacement therapy (gum, patch, candy, etc.)

☐ Referral (to a smoking cessation clinic or hotline)

points

Alcohol consumption

Evaluation Prescription

☐ Proper alcohol assumption ☐ Dangerous alcohol consumption ☐ High-risk alcohol consumption (Alcohol overuse, alcohol dependency)

☐ Consultation and education ☐ Medication therapy ☐ Referral (to Alcohol Anonymous, alcohol cessation clinic)

points

Exercise

Evaluation Prescription

☐ Insufficient ☐ Normal ☐ Sufficient

Type : ☐ Power walking ☐ Swimming ☐ Mountain climbing ☐ Aerobics ☐ Stretching

☐ Muscular exercise ☐ Others ( ) ☐ Referral

Time : ☐ 10 minutes ☐ 15–30 minutes ☐ Over 30 minutes ☐ Others

Frequency: ☐ 1–2 times a week ☐ 3–4 times a week ☐ More than 5 times a week

points

Nutrition

Evaluation Prescription

☐Bad ☐ Normal ☐ Good

☐ Please increase food intake. (☐ Dairy ☐ Proteins ☐ Vegetables and fruits)

☐ Please decrease (☐ Fat ☐ Simple sugar ☐ Salinity (Salt))

☐ Healthy eating habits (☐ Not skipping breakfast☐ Eating a balanced variety of foods)

☐ Referral (Nutrition education class)

points

Obesity

Evaluation Prescription

Body mass index: ☐ Low weight ☐ Normal weight ☐ Obesity ☐ Severe obesity

Waist measurement: ☐ Abdominal obesity

☐ Please decrease the amount of food intake. ☐ Please decrease daytime and nighttime snacks.

☐ Please decrease the amount and frequency of alcohol consumption. ☐ Please decrease dining out and fast food intake.

☐ Please refer to the exercise prescription. ☐ Referral (Obesity clinic)

☐ Others ( )

We hereby notify you of the health checkup (first examination) result for the lifetime transition period as above

. .

Determination date | Examined doctor | License (Qualification) number | Name (signature)

(Medical institution number)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital..

Chronic illness and improvement of lifestyle

“Disease information related to the objective disease”

[Annex No. 12]

Results of Dental Health Screening

☐ Regular checkup ☐ Life cycle–based checkup

Name of Examinee	Resident registration number	-	Health checkup institution ☐ visit, ☐on-site checkup	examination

How is the result of my oral checkup?

Determination - ☐ Normal A ☐ Normal B ☐ Caution ☐ Treatment required

● Mr./Mrs./Ms. , you need to take immediate actions for the following details.

● Mr./Mrs./Ms. , you need to have great focus to manage the following details.

How is the result of my oral examination?

Evaluation of questionnaire

(Dental department) Medical history issue	☐ No	☐ Yes				
Oral health awareness issue	☐ No	☐ Yes				
Oral health habit issue	Oral hygiene:	☐ No	☐ Yes	Fluoride use :	☐ No	☐ Yes
	Sugar intake:	☐ No	☐ Yes	Smoking :	☐ No	☐ Yes

Dental examination — Dental caries (cavity)

Decayed tooth	:	☐ No	☐ Yes
Tooth with interproximal caries suspected	:	☐ No	☐ Yes
Repaired tooth	:	☐ No	☐ Yes
Lost tooth	:	☐ No	☐ Yes

Periodontal biopsy — Periodontal disease

Gingivitis	:	☐ No	☐ Mild	☐ Severe
Dental plaque	:	☐ No	☐ Mild	☐ Severe

Dental examination

Result Note

▶ Prevalence of dental caries for permanent tooth (Year of 2010 / %)

(Ministry of Health and Welfare. 2010 National oral health survey. 2011

	Subjects	Male	Female
19–29 years old	39	42	35
30~39 years old	38	42	34
40~49 years old	34	37	31
50~59 years old	29	31	23
60~69 years old	28	33	23
Over 70 years old	27	31	25

▶ Description for examinations

- Decayed tooth: Tooth with dental caries
- Tooth of interproximal caries suspected Teeth of suspected dental caries taking place between teeth
- Repaired tooth: Tooth treated or repaired from dental caries by crowning gold, resin, or amalgam
- Lost tooth: Loosened tooth required to be replaced because of dental caries
- Gingivitis: Extent to which gums with inflammation

※ The following examinations are only applicable to health checkup for lifetime transition period for people "40 years old."

Dental plaque examination

Dental caries (cavity)
Periodontal disease (gum disease)

Dental plaque of the first upper right molar (No. 16)	:	points
Dental plaque of the upper right central incisor (No. 11)	:	points
Dental plaque of the first upper left molar (No. 26)	:	points
Dental plaque of the first lower left molar (No. 36)	:	points
Dental plaque of the lower central left incisor (No. 31)	:	points
Dental plaque of the first lower molar of the right (No. 46)	:	points
Average		**points**

Determination

- Good (Less than 1 point)
- Normal (Less than 1–3 points)
- Bad (More than 3 points)

※ **Average point** = sum of the points of every dental surface / the number of evaluated teeth

We notify the result of your oral checkup as above.

Determination date Dentist: License (Qualification) number Name (signature)

(Office code)

※ This notification letter of health checkup result can serve as a medical care referral (treatment referral) if it has an impression note that states that the subject is required to be treated at a more advanced hospital.

210㎜×297㎜[백상지 80g/㎡ 또는 NCR용기 2P 60g/m^2]

[Annex No. 2]

Results of Stomach Cancer Screening

Full Name		Residential ID No.	- 1(2)******

Classification	Test list (date of examination)		Results	Decision ※ Write it below following the examination rule
Stomach Cancer	Name of Test — date/year ※ Maximum 2 tests (Upper gastrointestinography, Endoscopy)	Opinion (location) ※ Write cancer location following the opinion.		
		Pathology ※ In case Tissue Test was not taken, leave this blank.		
	Recommendation			

Date of results	Date/Year	Examining physician	License No.	
			Name of doctor	(signature)

Results of Stomach Cancer Screening

※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ Stomach cancer has the highest incidence rate compared to all cancers in South Korea. It is possible to detect it through regular medical checkups and when detected early, it is commonly overcome through endoscopy remedy or surgery.

※ We recommend persons of both sexes who are over 40 to receive endoscopy or upper gastrointestinography every 2 years even if they do not experience any symptoms because the possibility of stomach cancer sharply increases after age 40.

※ If you experience symptoms, such as stomachache, heartburn, among others, please consult with a physician even though "no abnormality" was found from the stomach cancer examination. If your test result is not "no abnormality", please follow the physician's instructions.

We are notifying you of these medical examination results as follows.

Date/Year

Office code Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

[Annex No. 3]

Results of Liver Cancer Screening

Full Name		ID No.	- 1(2)******

Classification	Test list (date of examination)	Results	Decision ※ Write it below following the examination rule.
Liver Cancer	Name of examination — date/year ※ Maximum of 5 tests, including 2 or 3 tests for liver disease, ultrasonography, or Alpha-fetoprotein test.		
	Recommendation		

Date of results	Date/Year	Examining physician	License No.	
			Name of doctor	(signature)

Results of Liver Cancer Screening

※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ For those who are over 40 and belong to a high-risk group (liver cirrhosis, hepatitis-B antigen positive, hepatitis C antibody positive, a chronic liver disease patient because of hepatitis B or C virus), undergoing the liver cancer screening examination is recommended. (The liver ultrasound and serum alpha-fetoprotein examination are conducted every year.)

※ Not all cancers are diagnosed by this liver cancer screening. If you experience suspicious symptoms (such as loss of weight, jaundice, sudden fatigue, among others), please consult with a physician. If your test result is not "no abnormality", please follow the physician's instructions.

We are notifying you of these medical examination results as follows.

Date/Year

Office code Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

210 ㎜ × 297 ㎜ [백상지 80 g/㎡]

[Annex No. 4]

Results of Colon Cancer Screening

Full Name		ID No.	- 1(2)******

Classification	Test list (date of examination)		Results	Decision ※ Write it below following the examination rule.
Colon Cancer	Name of test — date/year ※ Maximum of 3 tests including fecal occult blood test (FOBT), digital rectal exam (DRE), or endoscopy	Opinion (location) ※ Record recommendations based on FOBT (no location of lesion). ※ The opinion regarding only FOBT does not need to be written down		
		Pathology ※ In case there is no pathology exam, leave this blank.		
	Recommendation			

Date of result	Date/Year	Examining physician	License No.	
			Name of doctor	(signature)

The Result of Colon Cancer Screening

※ ※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ The incidence rate of colon cancer has recently been on the rise. With this, it is possible to detect it through regular medical checkups and when found early, it is commonly overcome through endoscopy remedy or surgery.

※ Because of the sharp rise in the incidence of colon cancers on those over age 50, we recommend both men and women over 50 to have an annual fecal occult blood test screening even when there are no signs or symptoms. When the results of the fecal occult blood test come out abnormal, the presence of colon cancer can be confirmed by DRE or colonoscopy.

※ Not all colorectal diseases are diagnosed by fecal occult blood test. If you experience any suspicious symptoms (such as loss of weight, changes in thickness of stool, bloody stool, among others), please consult with a physician even though the result of the stool guaiac test is negative. If your test result is not "no abnormality", please follow the physician's instructions.

We are notifying you of these medical examination results as follows.

Date/year

Office code Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

[Annex No. 5]

Results of Breast Cancer Screening

Full Name		ID No.	- 1(2)******

Classification	The examination list (date of examination)		Results	Decision ※ Write it below following the examination rule.
Breast Cancer	X-ray mammography (date/year)	Opinion (location) ※ Write the cancer location following the opinion.		
	Recommendation			
	Date of results	Date/Year	Examining physician	License No.
				Name of doctor (signature)

The Result of Breast Cancer Screening

※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ The incidence rate of breast cancer has recently been on the rise. With this, it is possible to detect early and/or cure the said cancer through regular health checkups.

※ We recommend that persons over 40 receive breast X-ray every 2 years for early disease detection.

※ Even though no abnormality was found from the breast cancer screening test, a person that has undergone breast surgery in the past and has a lump around her breast must consult with a physician. If your test result is not "no abnormality", please follow the physician's instructions.

We are notifying you of these medical examination results as follows.

Date/year

Office code Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

[Annex No. 6]

Results of Cervical Cancer Screening

Full Name		ID No.	- 1(2)******

Classification	Test list (date of examination)		Results	Decision ※ Write it below following the examination rule	
Cervical Cancer	Pap smear screening (date/year)	Pathological types (biopsy procedures) ※ If you did not perform this exam, leave this blank.			
	Recommendation				
	Date of results	Date/Year	Examining physician	License No.	
				Name of doctor	(signature)

Results of Cervical Cancer Screening

※ (Health insurance subscribers) If the physician documents necessity of medical care in an advanced general hospital on the Results of Medical Checkup form, this form substitutes the request of medical care (request of medical exam). Presenting this form is sufficient to schedule a medical exam at an advanced general hospital.

※ (Medical care assistance recipient) If an abnormality is found as a result of the health checkup and the doctor's impression written in the checkup report as further evaluation is required, the report can be used as a referral for the subject to be treated at the same institution. In case you need another kind of medical care assistance than the given case, you should be treated according to the process of medical care assistance, Article 3, "Enforcement Rule of the Medical Care Assistance Act." In case of a subject applicable to the elective medical care institution system, he/she should first be treated at the medical institution that he/she has chosen.

※ It is possible to detect cervical cancer early through a biopsy screen test. In case of early detection, cervical cancer is commonly overcome with a simple surgery.

※ We recommend women who are over 30 with sexual experience to receive a biopsy screen test every 2 years.

※ If you experience symptoms, such as abnormal cervical bleeding, among others, please consult with a physician even though no abnormality was found from the cervical cancer screening test. If your test result is not "no abnormality", please follow the physician's instructions.

We are notifying you of these medical examination results as follows.

Date/year

Office code Office name

※ The cancer exam form follows the examination rule on extra cancer exam reports.

[Annex No. 19]

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 health checkup for the lifetime transition period),
☐ Health checkup for infants 〕

This consent form is made to obtain your agreement regarding providing your or your child's health checkup result to a public health center and its health management service history to the National Health Insurance Corporation (hereafter "Corporation") to provide health management service* by public health center system for the subjects who have diseases or are suspected as having hypertension, diabetes, dyslipidemia, declined cognitive function, etc., in the result of the general health checkup and health checkup for the lifetime transition period and for the parents of infants who are determined as further evaluation required and consistent management required in the result of the health checkup for infants.

* 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 National Health Insurance Corporation 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 National Health Insurance Corporation and consent to provide related details that I have been notified of.

① Institutions utilizing information: Public health center, National Health Insurance Corporation

② Purpose of providing personal information: to support health management service for those who require self-management and prevention measures and those who have disease (and suspected as having disease)

③ Personal information willing to provide

- Corporation → Public health center
  - Personally identifiable information, such as name, resident registration number, address, telephone number, e-mail, etc., and health checkup result and treatment via texting
- Public health center → Corporation : Name, resident registration number, health service management details that you have been offered

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 entire contents. ☐

Year Month Day

Consenter	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)				

210 ㎜ × 297 ㎜ [백상지 80 g/㎡]

[Annex No. 20]

Evaluation of Cognitive Function Difficulty for Those Aged 66, 70, 74

This questionnaire is for cognitive function difficulty. Please answer the following questions about your present condition compared to last year by ticking the appropriate box below. (This form should be completed by a guardian if the person in question cannot do so.)

Korean Dementia Screening Questionnaire—C	No (0 point)	Sometimes (1 point)	Almost every day (2 points)
1. I (He/She) do (does) not know what the day is today			
2. I (He/She) cannot find my own things.			
3. I (He/She) ask (asks) the same question over and over.			
4. I (He/She) forget (forgets) appointments.			
5. I (He/She) placed an object and I am (he/she is) not able to recall where the object is placed.			
6. I (He/She) cannot recall people's name or objects' name and has difficult time to say the name.			
7. I (He/She) do (does) not (understand conversations and I (he/she) ask (asks) someone about the conversation over and over.			
8. I (He/She) have (has) gotten lost in the middle of the road.			
9. I've (He/She has) lost the ability to calculate compared to last year. (example: I (he/she) cannot calculate the change or price)			
10. My (His/Her) personality has changed a lot.			
11. I (He/She) am (is) losing my (his/her) ability to use machinery. (washing machine, electric appliance, tracker, etc.)			
12. I (He/She) cannot organize things around the house.			
13. I (He/She) cannot choose the right clothes for the right occasion.			
14. I (He/She) cannot get to the destination alone by public transportation. (except in cases of physical difficulties, such as knee arthritis.)			
15. I (He/She) do (does) not want to change clothes even when they are dirty.			
Score	/ 30		

[Annex No. 21]

Evaluation of Depression for Those Aged 40

The items below are questions about your condition in the last week.
Please answer how often it happened in the last week.

In the last week...

① Rarely (less than once a week) ② Sometimes (1–2 days a week)
③ Occasionally (3–4 days a week) ④ Almost every day (over 5 days a week)

1. I was annoyed and bothered by things that were okay for me before.	①	②	③	④
2. I did not want to eat and I even lost my appetite.	①	②	③	④
3. I felt sad even when someone tried to help me.	①	②	③	④
4. I could not focus on any work.	①	②	③	④
5. I spent days relatively well.	①	②	③	④
6. I felt so sad.	①	②	③	④
7. I felt everything is so difficult.	①	②	③	④
8. I felt the future was gloomy.	①	②	③	④
9. I felt my whole life was a failure.	①	②	③	④
10. I thought I had the same capability like other people.	①	②	③	④
11. I could not sleep or had sleeping difficulty.	①	②	③	④
12. I felt fear.	①	②	③	④
13. I did not feel like talking as I used to.	①	②	③	④
14. I felt lonely as if I was left alone in the world.	①	②	③	④
15. I lived without major complaints.	①	②	③	④
16. I felt people were unfriendly toward me.	①	②	③	④
17. I burst into tears and felt like crying.	①	②	③	④
18. I felt as if my heart is broken.	①	②	③	④
19. I felt like everyone hated me.	①	②	③	④
20. I did not have any self-confidence to do anything.	①	②	③	④

※ Score: ① (0 point), ② (1 point), ③ (2 points) ④ (3 points) / total 60 points
(except Questions 5, 10, and 15 for they are not factors of depression)

[Annex No. 21-2]

Evaluation of Depression for those aged 66

Please answer the following questions about your present condition by ticking the appropriate box.

1. Are you satisfied with your life most of the time?	Yes	No
2. Have you become less active?	Yes	No
3. Do you feel you have not lived as planned?	Yes	No
4. Do you feel life is boring?	Yes	No
5. Do you feel recharged every day?	Yes	No
6. Do you feel nervous about the future?	Yes	No
7. Do you usually feel happy?	Yes	No
8. Do you sometimes feel miserable?	Yes	No
9. Do you want to stay indoors only and not go out all the time?	Yes	No
10. Do you feel your memory is worse than others at your age?	Yes	No
11. Do you feel happy to be alive?	Yes	No
12. Do you feel you are a useless person?	Yes	No
13. Do you have great energy?	Yes	No
14. Do you feel like you do not have any hope?	Yes	No
15. Do you feel your life is worse than others?	Yes	No
Total (Written by Examiner)		
Total Score (Written by Examiner)		

※ Score: Yes (1 point) No (0 point) Total 15 points (except **Questions 1, 5, 7, 11, and 13 for they are not factors of depression**)

(Annex No. 4)

Search for checkup institutions: Home page of NHIS (www. nhis.or.kr) / frequently searched menu / hospitals and checkup institutions / health checkup institutions

Verification for ____ Health Screening Candidate (For Presentation at the Examining Facility) (For Corporate Subscribers)

Name		ID card No.	**-1(2)******		
Name of workplace		Workplace transition No.			
Health insurance No.		Affiliated branch			
Management number of place of business		Work division[1)]		Department	
Address of place of business					

Examination facts and expenses				
1st exam	No charge	Vision, hearing, blood pressure, urine test, blood test, X-ray, oral exam, medical examination by interview, and other medical examinations ※ Examination period: until Dec. 31, ____	Exam for Hepatitis B (aged 40)[2)]	
Oral screening	No charge for a person	Dental examination periodontal tissue examination, **dental plaque test** (for 40 years old), oral health education, etc. ※ Examination period: until Dec. 31, ____		
2nd exam	No charge	Following the results of the 1st health exam, we work with a person who is suspected of high blood pressure, and/or diabetes. ※ Following the results of the 1st health exam, we work with the evaluation of life habits or mental health of a person who is a special health exam recipient aged 40 or 66. (Examination due by: January, 31, next year)		

Cancer Screening	Category	Stomach Cancer	Colon Cancer	Breast Cancer	Cervical Cancer	Information Agency[3)]
	Candidate/Cost[4)]					
	Medical expenses paid					
	Screening period	Until Dec. 31, ____.; the 2nd screening exam for stomach–colon cancer is by January, 31, next year				

※ In case of double examination, we have to charge to recoup additional medical expenses; the National Insurance Cooperation gets medical expenses back from the health exam recipient in the case of taking more than 1 medical checkup per period. (health exam period: office worker—every other year; non office worker—every year)

※ Because a "cancer screening checklist" is sent to the address of the corresponding subjects, please ensure that you do not receive cancer screening twice.

We confirm the health exam recipient in our office who is on the list above.

year month date

Employer's name: (signature)

Note1) Type of work: write separately for office workers and nonoffice workers (refer to the health exam recipient list)

Note2) Exam on Hepatitis B is only for those aged 40 (except Hepatitis B antigen carrier or antibody carrier)

Note3) Information Agency: the National Cancer Screening results are reported to candidates (public health center)

Note4) Declaration of cost burden.

① No cost sharing for examinees: All the cost of the 1st and 2nd general health checkup, the lifetime transition period health checkup, and cervical cancer-related examinations are paid by the corporation. In case of examinations related to the stomach, liver, colon, and breast cancer, 90% is paid by NHIS and 10% by the state.

② 10% cost to recipient: NHIS is responsible for 90%, recipient for 10%.

③ No application: nonapplier

④ Exam completion: person who is already done with the related exam.

⑤ If recipient of medicaid is diagnosed as a new cancer patient as a result of the national cancer screening service, part of the medical expense can be shouldered.

※ Age rule for cancer exam: stomach and breast cancer (over 40), colon cancer (over 50), liver cancer (over 40), and cervical cancer (over 30)

※ You can check the screening recipient, screening agency, and annual screening result from the Web page of the National Health Insurance Service (www.nhis.or.kr).

※ Please observe the health checkup precautions before being examined because the result can be inaccurate if you do not fast for 8 hours, if you had a night shift prior to the checkup, or if you are examined during your menstrual cycle.

※ "Liver cancer" is included in the cancer screening checklist, which is sent to the address of the corresponding subjects.

※ From 2015, for the office workers who are subjects of cancer screening, the period for their general health checkup and cancer screening is unified on the same year based on their year of birth (even, odd number) to be selected as a subject.

(Annex No. 5)

※ Health exams operated by the NHIS can be taken once every 2 years,
If a person takes the exam twice or more, we will charge the health exam recipient for the medical expenses.

※ Check information on the NHIS Web site (www.nhis.or.kr) or call our branch office (1577–1000).

printable page (address)

use as a substitute for medical exam list

---------- Do not tear off this paper, this paper can used for the address sheet for results ----------

Confirmation ____ for the Health Exam Recipient (use for presentation to examiner)

Full name		ID No.	**-1(2)*******

Examination facts and expenses

1st exam	No charge	Vision, hearing, blood pressure, urine test, blood test, X-ray, oral exam, medical examination by interview, and other medical examinations ※ The period of the exam: until Dec. 31, ____	Exam for Hepatitis B (age 40[1])	
Oral screening	No charge for a person	Dental examination periodontal tissue examination, d**ental plaque test** (for 40 years old), oral health education, etc. ※ Examination Period: until Dec. 31, ____		
2nd exam	No charge	Following the results of the 1st health exam, we work with a person who is suspected of high blood pressure and/or diabetes. ※ Following the results of the 1st health exam, we work with the evaluation of life habits or mental health of a person who is a special health exam recipient aged 40 or 66. (Examination Period: January, 31, next year)		

Cancer Screening	Category	Stomach cancer	Liver cancer	Colon cancer	Breast cancer	Cervical cancer	Information Agency[3]
	Candidate / Costs[2]						
	Medical expenses covered						
	Screening period	Until Dec. 31, ____. The 2nd screening exam for stomach–colon cancer is by January, 31, next year					

As above, we confirm the health exam recipient for _____.

. . .

National Health Insurance Co. President (signature)

Note 1) Exam for hepatitis B is only offered to those aged 40 (except hepatitis B antigen carrier or antibody carrier).

Note 2) Declaration of cost burden.

① No charge: the NHIS covers the entire expenses for persons who take health exams, such as the 1st and 2nd general health exam, cervical cancer exam, or special health exam for those aged 40, 66, and 70. The NHIS covers 80% and the country covers 20% for persons who are NHIS early cancer exam recipients taking the breast cancer, stomach cancer, liver cancer, and/or colon cancer exams.

② Enter out-of-pocket expenses for cancer screening (10% of cancer screening costs).
※ After calculating the recipient's burden through adding counseling fees and related exam payments, discount fees are under KRW 10.

③ No application: nonapplier

④ Exam completion: person who is already done with the related exam.

⑤ If cancer is confirmed, the patient can get some support for medical expenses.

Note 3) Information agency: the information agency is the place (public health center) for reporting examination results to the NHIS early cancer exam recipient.

※ Age rules for cancer examinations: stomach and/or breast cancer (over 40), colon cancer (over 50), liver cancer (over 40), and cervical cancer (over 30)

※ You can check the screening recipient, screening agency, and annual screening result from the Web page of the National Health Insurance Service **(www.nhis.or.kr).**

(Annex No. 6)

※ In the case of a person who takes a cancer exam operated by the NHIS twice or more, we charge the health exam recipient with the medical expenses.

※ Check the information on the NHIS Web site (www.nhis.or.kr) or call our branch office (1577-1000).

printable page (address)

use as a substitute for cancer exam list

---------- Do not tear off this paper, this paper can used for the address sheet for results----------

Confirmation ____ for Cancer Exam Recipient (Used for Presentation to Examiner)						
Full name			ID No.	-1(2)******		
Health insurance no.			Position			
Examination facts and expenses						
Category	Stomach cancer	Liver cancer	Colon cancer	Breast cancer	Cervical cancer	Information agency[3)]
Candidate/Costs[2)]						
Medical Expenses Covered						
Screening Period	Until Dec. 31, ____. The 2nd screening exam for stomach–colon cancer is due by January 31 of next year					
As written above, we confirm the health exam recipient for ____. . . . National Health Insurance Co. President (signature)						

Note 1) Declaration of a cost burden.

① No charge: the NHIS covers the entire expenses for the 1st and 2nd general health exam, cervical cancer exam, or special health exam for those aged 40, 66, and 70. The NHIS covers 90% and the country covers 10% for persons eligible for national early cancer exam recipients taking the breast cancer, stomach cancer, liver cancer, and/or colon cancer exams.

② Enter out-of-pocket expenses for cancer screening (10% of cancer screening costs)

※ After calculating the recipient's burden through adding counseling fees and related exam payments, discount fees are under KRW 10.

③ No application: nonapplier

④ Exam completion: person who is already done with the related exam.

⑤ If cancer is confirmed, the patient can get some support for medical expenses.

Note 2) Information agency: The information agency is the place (public health center) for reporting the exam results to the national cancer early exam recipient.

※ Age rules for cancer examinations: stomach and/or breast cancer (over 40), colon cancer (over 50), liver cancer (over 40), and cervical cancer (over 30)

※ You can check the screening recipient, screening agency, and annual screening result from the Web page of the National Health Insurance Service **(www.nhis.or.kr).**

(Annex No. 11)

Information for Health Exam Recipients

☐ General Health Examinations provided by the National Health Insurance Service are available every 2 years (every year for all workers except for white-collar workers). Life cycle-based checkups are available at age 40 and 66. The infant and toddler health examination is available for 4, 9, 18, 30, 42, 54, and 66 months of age. Cost for additional health examination unless specified above will be collected.

☐ When answering the questionnaire, it is very important material for a doctor to diagnose the examinee's condition or examination. Therefore, make sure that all necessary information are written on the sheet.

※ If you provide your e-mail address and agree to the subscription of information, you will be receiving health-related information and news provided by NHIS or the health center.

☐ The cancer examinations can be provided only for a few of the tests based on your preference and the examinee will need to cover 10% of the medical expenses. (Cost for cervical cancer, subjects of the national cancer screening, and the life cycle-based checkup are 100% covered by NHIS).

☐ A colorectal cancer test is for those who are over 50 years old. A fecal occult blood test makes up the 1st screening. Only people whose 1st screening turned out to be positive can select either undergo a colon double contrast test or endoscopy as the 2nd test.

☐ Cost for general health examination, life cycle-based checkups, and cervical cancer screening will be completely covered by NHIS.

☐ Life cycle-based checkups are only available once in corresponding age, in other words, once in a lifetime.

☐ People who are taking the 1st special health exam will be the next health exam recipients. The prescription for improving life habits through the evaluation (smoking, drinking alcohol, exercising, overweight, nutrition) cannot be used for medication or drugs.

☐ Please follow the health exam regulations. Results will be inaccurate if people do not have an empty stomach over 8 hours before the health exam, have worked overnight, or have taken the health exam during their period (for women).

(Annex No. 12)

Smoking Habits Evaluation

Examinee's name	

Please answer the following questions about your present condition by ticking the appropriate box.

1. Do you plan to stop smoking?

□ ① I plan to stop smoking within a month.

□ ② I plan to stop smoking within 6 months.

□ ③ I am thinking about stopping, but not within 6 months

□ ④ I do not have any intention to stop smoking right now.

2. Can you stop smoking right now (0–7)?

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7

(Not at all) (For sure)

3. How soon do you light up your first cigarette after waking up?

□ Within 5 minutes (3 points)

□ Between 6–30 minutes (2 points)

□ Between 31–60 minutes (1 point)

□ After 60 minutes (0 point)

4. Do you have difficulty holding the urge to smoke in nonsmoking areas, such as churches, theaters, or libraries?

□ Yes (1 point)

□ No (0 point)

5. In which occasion is it most difficult for you to give up smoking?

□ The first cigarette in early morning (1 point)

□ Others (0 point)

6. How many cigarettes do you smoke a day?

□ Under 10 cigarettes (0 points)

□ 11–20 cigarettes (1 point)

□ 21–30 cigarettes (2 points)

□ Over 31 cigarettes (3 points)

7. Do you smoke more cigarettes within a few hours after waking up than the later hours?

□ Yes (1 point)

□ No (0 points)

8. Do you still want to smoke even when you are very sick?

□ Yes (1 point)

□ No (0 point)

Total	

(Annex No. 12-2)

Smoking Cessation Prescription

Date of visiting:
Examinee name: **Gender: Male/ Female**

1. Present smoking status

□ Ex-smoker □ Light smoker □ Heavy smoker

2. Nicotine dependency

□ Low □ Medium □ high

You can improve your quality of life if you stop smoking.

3. Smoking prescription

□ Need education or counseling to stop smoking. Please read the stop-smoking brochure.

□ Need nicotine replacement therapy.

_____

_____

□ Need to take medication to aid smoking cessation (i.e., Bropion).

_____

_____

□ Refer to smoking cessation services (i.e., smoking cessation clinic or smoking cessation call center or quitline).

□ Others: _____

4. Status of health problems that can be improved when one stops smoking.

□ High blood pressure □ Diabetes

□ Heart disease □ Hyperlipidemia

□ Stroke □ Peripheral circulatory disturbance

□ Chronic bronchial trouble □ Asthma

□ Paranasal sinusitis □ Gastric/Duodenal ulcer

□ Surgery complication □ Family health

□ Bad breath □ Decrease of immune function

□ Wound healing retardation □ Sexual impotence

□ Lumbago & ruptured disk □ Osteoporosis

□ Others:_____

You might require regular clinic visits to assist you with smoking cessation.

Physician's name: (signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

(Annex No. 12-3)

Alcohol Habit Evaluation

Examinee's name	

Please answer the following questions about your present condition by ticking the appropriate box.

1. How often do you drink alcoholic beverages?

□ Never (0 point) □ Less than once a week (1 point) □ 2–4 times a month (2 points)
□ 2–3 times a week (3 points) □ Over 4 times a week (4 points)

2. How many alcoholic beverages do you have in a typical day when you drink?

(Regardless of the types of alcohol beverages, count the total number of glasses. For beer, 1 can of beer, 350 cc of draft beer, or 1 bowl of Mak-Gul-li, is counted as 1 glass)

□ 1–2 (0 point) □ 3–4 (1 point) □ 5–6 (2 points)
□ 7–9 (3 points) □ over 10 (4 points)

3. How often do you have 6 or more drinks in 1 occasion?

□ Never (0 point) □ Less than once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

4. How often during the last year have you found yourself not able to stop drinking once you started?

□ Never (0 point) □ Less than once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

5. How often during the last year have you failed to perform you daily work because of drinking?

□ Never (0 point) □ Less than once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session from the previous night?

□ Never (0 point) □ Less than once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

□ Never (0 point) □ Under once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

□ Never (0 point) □ Less than once a month (1 point) □ Once a month (2 points)
□ Once a week (3 points) □ Almost every day (4 points)

9. Have you or someone else been injured a result of your drinking?

□ No (0 point) □ Yes, but not in the last year. (2 points)
□ Yes, during the last year. (4 points)

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you to cut down?

□ No (0 point) □ Yes, but not in the last year. (2 points)
□ Yes, during the last year. (4 points)

Total	

(Annex No. 12-4)

Stop Drinking or Drinking in Moderation Prescription

Date of visit:

Examinee's name: **Gender: male/female**

1. Present drinking state

□ Normal □ Danger

□ Misuse of alcohol □ Alcoholic

2. Stop drinking or drinking in moderation prescription

1) Need education or counseling

□ Certainly need to stop drinking for ( ) days.

□ Never drink over ( ) glasses a day, never drink a total of ( ) glasses a week.

□ Keep discontinuation for a total of ( ) days a week.

□ Bring a written drinking diary for 2 weeks.

□ Read the nondrinking brochure.

2) Need to take medicine or drugs

□ Prescribe medicine for reducing drinking desire

_____

□ Others: _____

3. Health problems that can be improved when one stops drinking

□ Depression □ Stomach disease

□ High blood pressure □ Heart disease

□ Diabetes □ Stroke

□ Hyperlipidemia □ Osteoporosis

□ Overweight □ Problems relevant to work

□ Interpersonal relation □ Accidents

□ Others:

☞ **We advise you to get additional professional help**

Physician's name: (signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

(Annex No. 12-5)

Evaluation of Physical Exercise Habits

Examinee's name		I would like to take the Evaluation of Physical Exercise Habits. □

Please answer the following questions about your present condition by ticking the appropriate box.

1. During the last week, how many days did you exercise vigorously for over 20 minutes until you were almost out of breath?
(example: heavy lifting, digging, jogging, aerobics, strenuous cycling)
□ 0 □1 □2 □3 □4 □5 □6 □7+

2. During the last week, how many days did you exercise in a moderate level for more than 30 minutes until you had to breathe a little faster than usual?
(example: light exercise, walk to work or walk for leisure, etc.)
□0 □1 □2 □3 □4 □5 □6 □7+

3. During the last week, how many days did you walk for the total of 30 minutes or more in a day, including separate 10-minute walks each time?
(ex: fast walking, tennis, bicycle riding, cleaning, etc.)
□ 0 □1 □2 □3 □4 □5 □6 □7+

Total

4. Have you ever been told that you have to exercise by a doctor's recommendation because of a heart problem?
□ Yes □ No

5. Have you ever experienced chest pains during exercise?
□ Yes □ No

6. Have you ever experienced chest pains even when you did not exercise last month?
□ Yes □ No

7. Have you ever lost your balance because of loss of consciousness or dizziness?
□ Yes □ No

8. After trying a different exercise, have you ever experienced a bone or joint problem?
□ Yes □ No

9. Have you ever received any prescription from a doctor because of heart problems or blood pressure?
□ Yes □ No

10. Do you have any other reason for not exercising?
□ Yes □ No

(Annex No. 12-6)

Prescription for Exercise Habits

Date of visit:

Examinee's name: **Gender: Male/Female**

1. Present exercise status

□ Insufficient for maintaining health.

□ Not enough to improve your health although health can be maintained.

□ Improving your health.

2. We recommend the following types of exercises to improve your health and quality of life.

1) Types of exercise you should do

□ Fast walking	□ Walking	□ Mountain hiking
□ Swimming	□ Water activities	□ Riding a bicycle
□ Aerobics	□ Dance	□ Yoga
□ Weights	□ Others:	

2) Exercise duration

□ 10 minutes □ 15–30 minutes □ Over 30 minutes □ Others:

3) Exercise frequency

□ 1–2 times a week □ 3–4 times a week □ over 5 times a week

3. Health problems or conditions can be improved through exercise.

□ Overweight	□ Stress	□ High blood pressure
□ Diabetes	□ Heart disease	□ Stroke
□ Hyperlipidemia	□ Osteoporosis	□ Pain in bones or joints
□ Injury from a fall	□ Depression	□ Others

☞ **We advise you to get additional professional help**

Physician's name: (Signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

(Annex No. 12-7)

Evaluation of Diet Habits

Examinee's name		**I would like to take the Evaluation of Diet Habits.** □

Please answer the following questions about your present condition by ticking the appropriate box.

1. I drink dairy products, such as milk, soybean milk, among others, more than 1 glass (over 200 ml) every day.

□ Usually (5 points) □ Sometimes (3 points) □ Never (1 point)

2. I eat meat, fish, egg, bean, or tofu more than 3 times a day.

□ Usually (5 points) □ Sometimes (3 points) □ Never (1 point)

3. I include vegetables in every meal.

□ Usually (5 points) □ Sometimes (3 points) □ Never (1 point)

4. I eat fruit (more than 1 serving) or drink fruit juice every day.

□ Usually (5 points) □ Sometimes (3 points) □ Never (1 point)

5. How often do you have stir-fried food?

□ More than 4 times a week (1 point) □ 2–3 times a week (3 points)
□ Less than 1 time a week (5 points)

6. How often do you have food containing cholesterol, such as bacon, egg yolk, squid, etc.?

□ More than 4 times a week (1 point) □ 2–3 times a week (3 points)
□ Less than once a week (5 points)

7. I eat one of these—ice cream, cake, snack or drinks (coffee, cola, sweet drinks)—every day.

□ Usually (1 point) □ Sometimes (3 points) □ Never (5 points)

8. I eat salted fish, soy sauce-seasoned dried vegetables, and other salty foods.

□ Usually (1 points) □ Sometimes (3 points) □ Never (5 points)

9. I always have my meals on time.

□ Usually (5 points) □ Sometimes (3 points) □ Never (1 point)

10. Do you eat at least 1 of each of the food groups, such as dairy products, meat or fish, fruits, vegetables, and grain, every day?

□ 5 types (5 points) □ 4 types (3 points) □ less than 3 types (1 point)

11. How often do you eat out?

□ More than 5 times a week (1 point) □ 2–4 times a week (3 points)
□ Less than once a week (5 points)

Total	

(Annex No. 12-8)

Prescription for Nutritional Life Habits

Date of visit:
Examinee's name: **Gender: male/female**

1. Present diet habits

□ Needs much improvement.
□ Normal.
□ Can prevent disease and maintain health.

2. Improvement of diet habits.

□ Drink more than 1 glass of milk, low-fat milk, or soybean milk containing calcium every day.
□ Eat a small portion of meat, tofu, bean, or fish more than 3 times a day.
□ Have vegetables during every meal.
□ Eat more than 1 serving of fruit and drink more than 1 glass of fruit juice.
□ Have seasoned, steamed, or roasted dishes, rather than fried dishes.
□ When you eat meat, if possible, eat lean meat and eat chicken and duck without the skin. Do not often eat eel, fish stomach, and fish eggs.
□ Do not have any sugary snacks, such as ice cream, snacks, or cake.
□ Eat more solid food items rather than soup and reduce intake of salty food.
□ Never skip breakfast and have regular meals.
□ Keep a balanced diet.
□ If possible, cut the number of times you eat out and if you do eat out, please avoid food that is too salty, too spicy, or too oily.
□ Drink at least 8 glasses of water every day (general recommendation).

3. Health problems or conditions that can be improved through healthy eating habits.

□ High blood pressure
□ Heart disease
□ Stroke
□ Osteoporosis
□ Gout
□ Diabetes
□ Hyperlipidemia
□ Peripheral blood vessel trouble
□ Overweight
□ Others

We advise you to get additional professional help

Physician's name: (Signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

(Annex No. 12-9)

Evaluation of Weight Control Habits

Examinee's name		**I would like to take the Evaluation of Weight Control Habits. □**

Please answer the following questions about your present condition by ticking the appropriate box.

◆ **Height:_____cm** ◆ **Weight:_____kg**

◆ **Waist:_____cm** ◆ **Body mass index:_____kg/m^2**

1. Do you weigh more (10 kg) now than when you were in your teens or early 20s?

□ Yes □ No

2. How many times have you tried to lose weight?

□ Never □ 1–3

□ Over 4 □ Always

3. Are you interested in losing weight?

□ No □ A little bit interested □ Very interested

(Annex No. 12-10)

Weight Control Prescription

Date of visit:
Examinee's name: **Gender: Male/Female**

◆ **Height:_____cm** ◆ **Weight:_____kg**
◆ **Waist:_____cm** ◆ **Body mass index:_____kg/m2**

1. You are
□ underweight. □ normal
□ overweight. □ obese.

2. You have excessive fat around the abdomen.
□ Yes □ No

3. Because of your weight, your risk level of developing chronic diseases, such as CVDs, hypertension, diabetes, high cholesterol, among others, is
□ low. □ normal. □ a little increased.
□ more increased. □ sharply increased. □ very sharply increased.

4. Recommended weight goal:
○ We recommend to lose your weight down to ( )% as the first goal.
○ Your first weight goal is kg.
○ The period of primary weight loss is within months.
○ Weight loss each month is kg.

5. Prescription to treat obesity
□ Reduce meal portions □ Reduce snacks or midnight munchies
□ Reduce eating out or fast food
□ Smoking □ Drinking □ Exercising □ Get nutrition prescription
□ Need to take medication
□ Others:

6. Health problems or conditions that can be improved if you keep the normal range of weight after weight loss.
□ Angina pectoris / cardiac infarction □ Diabetes □ Stroke
□ High blood pressure □ High cholesterol □ Peripheral blood vessel disease
□ Sleep apnea syndrome □ Incontinence □ Spine or bone problems
□ Gallbladder stone □ Others:

☞ **We advise you to get additional professional help**

☞ **You need regular clinic visits to assist you in losing weight.**

Physician's name: (Signature)

※ This prescription cannot be used for medication. It is only for developing life habits.

(Annex No. 7)

* Check more information on infant/toddler health exam through NHIS's Web site www.nhis.or.kr or call 1577-1000.

(Address)

use as a substitute for infant/toddler health exam list

Confirmation for the infant / toddler / children at preschool age exam recipient (use for presentation to examiner)

Full name		ID No.	
Health insurance no.		Branch office	

Months of Examination & Time

Months of Examination	Health exam period		Information agency	Exam existence
4 mos	Health Exam (4–6 mos)		Health center code /NHIS	Completion/ expiration/recipient
9 mos	Health Exam (9–12 mos)		"	"
18 mos	Health Exam (18–24 mos)		"	"
	Dental Exam (18–29 mos)		"	"
30 mos	Health Exam (30–36 mos)		"	"
42 mos	Health Exam (42–48 mos)		"	"
	Dental Exam (42–53 mos)		"	"
54 mos	Health Exam (54–60 mos)			
	Dental Exam (54–65 mos)			
66 mos	Health Exam (66–71 mos)			

Exam facts for infant / toddler / children at preschool age

Health exam	Oral health exam
○ Interview and exam: questionnaire, hearing exam, vision exam ○ Body measurement: height, weight (body mass index), head circumference ○ Health education: injury prevention, nutrition & physical activity counseling, sleep position counseling, oral health, preschool counseling, secondhand smoking ○ Development evaluation and counseling: examination and counseling by Korea Development Screening Test for Infants & Children (K-DST)	○ Oral health interview or exam: questionnaire, dental exam, oral exam, etc. ○ Oral health education: for parents or child using manual.

No expenses for all health exams.

As above, we confirm the infant / toddler / children at preschool age exam recipient for 0000.

. . .

National Health Insurance Co. President (signature)

Note) 1. Infant/toddler health examinations is available for 10 times from 4 months old to 71 months of age (including 3 times of dental examination).

2. In case you take more examinations than normal, which are taken before or after the regular exams, we will charge you for the additional medical examination fees.

3. If you lost the health examination card, apply to the National Health Insurance Co. (telephone: 1577-1000), which can reissue the card. Furthermore, you can also find more information, such as the exam results or examinee or exam center, through the NHIS's Web site (www.nhis.or.kr). Just click on the box "Civil service/health exam".

4. The appropriate public health center will cover all medical expenses for examinees who are on the list and the NHIS takes charge of the paperwork on giving the exam expenses.

[Annex No. 5] For 4~6 months

Health checkup questionnaire for infants (for 4–6 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: _____ year _____ month _____ day
2. Birth weight: ___.___ kg (round off to the nearest tenth)
3. Was the baby born prematurely? ① Yes (☞Expected date of confinement? _____ Year _____ Month _____ Day) ② No
4. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B
Numbers completed						

Vision

		Yes ①	No ②
1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Are the baby's pupils unclear?	①	②
4	Does any of your family members have an eye-related genetic disorder?	①	②

Education for prevention of sudden infant death syndrome

		Yes ①	No ②
1	Do you have the baby sleep with his/her face down?	①	②
2	Is the bed or mattress of the baby fluffy?	①	②
3	Do parents sleep on the same bed (or mattress, etc.) with the baby?	①	②
4	Do you help the baby play with his/her abdomen down to the floor and head up when the baby is awake?	①	②
5	Are there any smokers among the family members living with the baby or the person the baby frequently gets in contact with?	①	②
6	Is there any person who smokes inside of your home (including balcony)?	①	②
7	Is there any person who smokes inside of the car that the baby rides in?	①	②

Auditory sense

		Yes ①	No ②
1	Does the baby show responses to loud noises such as waking up, being startled, changing facial expression, etc.?	①	②
2	Does the baby seem to calm down or stop moving to listen to the sound when a familiar voice is talking?	①	②
3	Is the baby able to make various sounds (squeaking, guffawing, screaming in high tones, etc.)?	①	②
4	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
5	Did the baby receive a hearing screening test in the newborn period?	①	②
6	If you answer "yes" to question 5, was the test result good (passed for both ears or no abnormality)? (If the answer to question 5 is "No", please skip this question.)	①	②

Accident preventative education

		Yes ①	No ②
1	Where do you install the car seat when you have the baby in a car? ① Front seat ② Rear seats (If you do not have a car seat or a car ③)	①	② ③
2	Do you install the car seat for the baby to face the rear?(If you do not have a car seat or a car ③)	①	② ③
3	Have you ever left your baby alone on an adult's bed or a sofa even if for a second?	①	②
4	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②
5	Have you ever consumed a hot drink while holding the baby?	①	②

Nutrition education

1 Common	What food do you mainly feed your baby? ① Only breast milk(☞ Questions 2–4, 10) ② Only powdered formula (☞ Questions 5–10) ③ Mixture of breast milk and powdered formula (☞ Questions 2–10				① ② ③
2 Breast milk	Until when will you keep feeding your baby with breast milk? ① 6–11 months old ② 12–23 months old ③ Over 24 months old ④ I don't know.	① ② ③ ④	5 Powdered formula	How much formula does the baby have in a day? ① Less than 500 mL ② 500–999 mL ③ More than 1,000 mL	① ② ③
			6 Powdered formula	Do you use boiled and cooled water when you make the formula? ① Yes ② No	① ②
3 Breast milk	hat kind of problems do you have that hinder you from continuing breast-feeding?① Amount of breast milk ② The number of breast-feeding instances ③ The way of breast-feeding ④ Breast-feeding in the nighttime ⑤ Others ⑥ No problem	① ② ③ ④ ⑤ ⑥	7 Powdered formula	How do you warm up the formula made in advance? ① Water bath ② Microwave ③ Others	① ② ③
			8 Powdered formula	How did you choose the powered formula currently being provided to the baby? ① Selected by the guardian ② Recommended by a doctor	① ②
4 Breast milk	Which of the following does the mother of the baby consume? ① Caffeinated drinks ② Alcoholic drinks ③ Cigarettes ④ Drugs ⑤ Not applicable	① ② ③ ④ ⑤	9 Powdered formula	What do you do with the leftover formula? ① Save it for another time ② Discard it	① ②
1 Common	When do you plan to start weaning and providing supplementary meals for an infant (baby food)? ① Already started before the baby became 4 months old. ② 4–6 months old ③ After 6 months old ④ I don't know.				① ② ③ ④

[Annex No. 5-2] For 9~12 months ●○

Health checkup questionnaire for infants (for 9–12 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment .

1. Date of birth of child: _____ Year _____ Month _____ Day

2. Birth weight: ___.___ kg (round off to the nearest tenth)

3. Was the baby born prematurely? ① Yes (☞Expected date of confinement? _____ Year _____ Month _____ Day) ② No

4. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B
Numbers completed						

5. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Is your baby able to make good eye contact?	①	②
2	Does the position of the pupil of the baby seem strange? (Are the eyes gathering inward or outward even without focusing?)	①	②
3	Are the baby's pupils unclear?	①	②
4	Does any of your family members have an eye-related genetic disorder?	①	②

Auditory sense

		Yes ①	No ②
1	Does the baby respond to the sound of calling names, telephone rings, human voice, etc.?	①	②
2	Is the baby cooing and babbling even when he/she is alone?	①	②
3	Does the baby follow to see where the sound is coming from?	①	②
4	Does the baby listen to you as a form of concentration when you are talking to him/her?	①	②
5	Does the baby make sounds resembling the sound of b, p, and m?	①	②

Accident preventative education

		Yes ①	No ②
1	Does the baby play with small objects such as peanuts, grapes, or buttons?	①	②
2	Have you ever had the baby ride on a baby walker?	①	②
3	Do you put hot drinks or food on the edge of the table?	①	②
4	Have you ever left your baby sit alone in a basin, bathtub, or restroom even if for a second?	①	②
5	Do you install the car seat for the baby to face the rear? (If you do not have a car seat or a car ③)	① ② ③	

Oral health education

		Yes ①	No ②
1	Does the baby sleep with a feeding bottle in his/her mouth or while being breast-fed?	①	②
2	Are you training the baby to wean from a feeding bottle?	①	②
3	Do you think the baby has dental caries?	①	②
4	Does the baby have any tooth with white spots?	①	②
5	Do you think the oral hygiene of the baby is in good condition?	①	②
6	Do you brush the teeth of the baby regularly?	①	②

Nutrition education

1	How many times does the baby have supplementary food (baby food)? ① Once ② 2 times ③ 3 times ④ Over 4 times	① ② ③ ④
2	What kind of food do you feed the baby with as supplementary food (baby food)? (Please check all corresponding numbers if applicable.) ① Grain ② Vegetables ③ Fruit ④ Egg ⑤ Fish ⑥ Meat	① ② ③ ④ ⑤ ⑥
3	What are you currently feeding the baby with? (Please check all corresponding numbers if applicable.) ① Breast milk ② General powdered formula ③ Specialized powdered formula ④ Fresh milk ⑤ Fermented dairy products (Cheese/plain yogurt, etc.)	① ② ③ ④ ⑤
4	Have you ever fed the baby with the following food? (Please check all corresponding numbers if applicable.) ① Grain powder ② Honey ③ Salt or sugar ④ Not applicable	① ② ③ ④

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[Annex No. 5-3] For 18~24 months ●○

Health checkup questionnaire for infants (For 18–24 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: Year Month Day

2. Birth weight: . kg (round off to the nearest tenth)

3. Was the baby born prematurely? ① Yes (☞Expected date of confinement? Year Month Day) ② No

4. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									

5. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Does your baby have difficulty in making eye contact, or do his/her pupils falter?	①	②
2	Are the baby's pupils unclear?	①	②
3	Does the baby rotate or tilt his/her head to see forward (objects in front of him/her) with his/her lateral staring?	①	②
4	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②

Accident preventative education

		Yes ①	No ②
1	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	①	②
2	Did you put the baby's bed away from the window or curtains?	①	②
3	Do you change the direction of the handle of kitchen utensils on the stove so that it is out of your baby's reach?	①	②
4	Have you ever left your baby sitting alone in a basin or bathtub even if for a second?	①	②
5	How do you have your child seated in a car? ① Using a car seat ② Using a booster seat ③ Fastening a seat belt ④ Just seated without any equipment	① ③	② ④

Auditory sense

		Yes ①	No ②
1	Is the baby able to distinguish the sound of regular level from every direction?	①	②
2	Does the baby understand and respond to the simple yes/no questions such as "Are you hungry?" or "Do you want to pee?"	①	②
3	Is the baby able to say his/her name (even if it is not very accurate)?	①	②
4	Is the baby able to locate the picture of the object in a book when you are telling its title?	①	②
5	Does the baby understand as hearing simple oral instructions (Give me a cup, bring the ball, etc.)?	①	②

Toilet training

		Yes ①	No ②
1	Has the urinating term of the baby prolonged than before? (about 2 hours)	①	②
2	Is the child able to put his/her pants down by him/herself?	①	②
3	Is the child able to understand or express words regarding defecation and urination (poop, pee, etc.)?	①	②
4	Does the child show interest in the potty?	①	②
5	Does the child defecate smoothly and regularly?	①	②
6	Have you ever tried toilet training?	①	②

Nutrition education

1	Does the child have regular meals at designated place on a fixed time? ① Yes ② No	① ②
2	Is the child using a feeding bottle? ① Yes ② No	① ②
3	How do you cook your child's food? ① Use just the same amount of salt as that found in an adult's food ② Use less salt than that found in an adult's food ③ Do not use salt at all	① ② ③
4	How much amount of fruit juice or sugar-added beverage (e.g., carbonated drink, sports drink, kids' drink, etc.) does the child drink a day? ① Less than 200 mL (1 full cup) ② 200–499 mL ③ Over 500 mL	① ② ③
5	What kind of food do you give the child during a day? (Please check all corresponding numbers if applicable.) ① Grain ② Vegetables ③ Fruit ④ Meat/fish/egg/bean ⑤ Milk and dairy products ⑥ Others	① ② ③ ④ ⑤ ⑥
6	How does the child react when you give him/her food? ① He/she eats well and evenly whatever is given. ② He/she eats only one or two food items that he/she wants to eat. ③ He/she does not pick a certain food to eat but eat just a little amount. ④ He/she hates food that he/she has to chew. ⑤ He/she shows no interest in food.	① ② ③ ④ ⑤
7	Do you enjoy sharing a meal with your child? ① Yes ② No	① ②
8	Do you offer the child dietary supplements other than meals? (e.g., vitamins, minerals, probiotics, red ginseng, etc.) ① Yes ② No	① ②

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[Annex No. 5-4] For 30~36 months ●○

Health checkup questionnaire for infants (for 30–36 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: _____ Year _____ Month _____ Day

2. Birth weight: ___.___ kg (round off to the nearest tenth)

3. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									

4. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Does your baby have difficulty in making eye contact, or do his/her pupils falter?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	①	②

Accident preventative education

		Yes ①	No ②
1	Does your child play on the road where cars are passing by?	①	②
2	Are there safety devices for the child in the stairways, windows, and balcony areas?	①	②
3	Do you keep matches or lighters out of reach of children?	①	②
4	Have you ever left your child alone in a car?	①	②
5	Do you keep electronic appliances that might hurt the child, such as electrical cords, outlets, etc., out of reach of children?	①	②
6	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	①	②
7	How do you have your child seated in a car? ① Using a car seat ② Using a booster seat ③ Fastening a seat belt ④ Just seated without any equipment	① ③	② ④

Auditory sense

		Yes ①	No ②
1	Does the number of words the child can speak continuously increase?	①	②
2	Is the child able to speak by connecting two clauses? (e.g., "Give them all.", "Read me books.", etc.)	①	②
3	Does the child turn up the TV volume louder than other people do?	①	②
4	Is the child able to use words that include consonants such as k, t, p, g, etc.?	①	②
5	Has the child infected with acute otitis media several times? (more than 4 times in 6 months, more than 6 times in 1 year)	①	②

Electronic media

		Yes ①	No ②
1	Is the TV or Internet available for use in the room where the child sleeps?	①	②
2	Do you have your own rules in your home about the use of the TV, Internet, or smartphones?	①	②
3	Do you know what kind of applications or video games the child use frequently?	①	②
4	Do you join your child when he/she uses a smartphone or the Internet or watch TV, movie, videos, etc.?	①	②
5	Does the child use a smartphone while lying down on his/her back or abdomen?	①	②

Nutrition education

1	How is the appetite of the child? ① Good ② Middle ③ Bad	① ② ③
2	How many times does your child have a meal? ① Once ② 2 times ③ 3 times ④ Over 4 times	① ② ③ ④
3	How many times does your child have a snack? ① Once ② 2 times ③ Over 3 times	① ② ③
4	How many days in a week does the child have a meal with the family? ① 1–2 days ② 3–4 days ③ More than 5 days	① ② ③
5	How many times does your child drink fresh milk? ① He/she does not drink at all. ② Less than 200 mL ③ 200–499 mL ④ 500–999 mL ⑤ Over 1,000 mL	① ② ③ ④ ⑤
6	Does the child eat a lot of sweet food? (e.g.: candy, snack, cake, fruit juice, sugar-added beverage, etc.) ① Yes ② No	① ②
7	Have you ever restricted certain food to the child because of worries related to allergic reactions? ① Yes ② No	① ②
8	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

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[Annex No. 5-5] For 42~48 months

Health checkup questionnaire for infants (for 42–48 months old)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: _____ Year _____ Month _____ Day

2. Birth weight : ___.___ kg (round off to the nearest tenth)

3. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									

4. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment?

① Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Does the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering one eye?	①	②

Emotion and sociality education

		Yes ①	No ②
1	Does the child voluntarily play with kids in his/her age group?	①	②
2	Does the child hurt his/her friend/s often, or deprive him/her/them of belongings?	①	②
3	Did you start to teach the child to do simple household errands? (e.g., Disposing waste in a waste bin, cleaning up his/her toys after playing, etc.)	①	②
4	Do you teach the child to behave in public places?	①	②
5	Do you teach the child to say hello first when he/she run into the acquaintance? / Do you teach the child to say "Thanks." or "Thank you." when somebody does a favor to him/her?	①	②
6	Is the child able to perform imagination play and role-playing? Is the child able to play in groups as dividing the sides?	①	②
7	Is the child able to explain what he/she has experienced in a simple manner?	①	②
8	Is the child able to explain jobs and roles that he/she frequently sees?	①	②

Auditory sense

		Yes ①	No ②
1	Is the child able to listen and repeat correctly the words (pencil, school, etc.) whispered from the distance of an arm radius in a quiet setting with his/her one ear covered at a time?	①	②
2	Are you able to understand the majority of what the child speaks?	①	②
3	Has the baby been hospitalized in a newborn intensive care unit (NICU) over 5 days after his or her birth?	①	②
4	Is the pronunciation of the child accurate?	①	②
5	Does the child speak as well as kids in his/her age group?	①	②

Accident preventative education

		Yes ①	No ②
1	Are there safety devices, such as a safety door or latch, for the child in the stairways, windows, and balcony areas?	①	②
2	Have you ever left your baby sitting alone in a pool or bathtub?	①	②
3	Do you keep cigarettes, lighters, electronic appliances, and electrical cords out of reach of children?	①	②
4	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
5	Does your child play on the road where cars are passing by?	①	②
6	How do you have your child seated in a car? ① Using a car seat ② Using a booster seat ③ Fastening a seat belt ④ Just seated without any equipment	① ② ③	② ③ ④

Nutrition education

1	How many times does your child have a meal? ① Once ② 2 times ③ 3 times ④ Over 4 times	① ② ③ ④
2	How many times does your child have a snack? ① Once ② 2 times ③ Over 3 times	① ② ③
3	How many times does your child drink fresh milk? ① He/she does not drink at all ② Less than 200 mL ③ 200–499 mL ④ 500–999 mL ⑤ Over 1,000 mL	① ② ③ ④ ⑤
4	How much amount of fruit juice or sugar added beverage (e.g. carbonated drink, sports drink, kids drink, etc.) does the child drink a day? ① Less than 200 mL (1 full cup) ② 200–499 mL ③ Over 500 mL	① ② ③
5	Do you ensure that the food you cook for the child and the family has low salt content? ① Yes ② No	① ②
6	How is the attitude of the child in a dining table? (Please check all corresponding numbers if applicable.) ① He/she takes too long time to finish a meal. (over 30 minutes) ② He/she refuses to eat new kinds of food. ③ He/she only eats what he/she wants to eat. ④ It is hard to make him/her eat. ⑤ Not applicable	① ② ③ ④ ⑤
7	Does your child watch TV or is exposed to the monitor (computer, game console, smartphone, etc.) for over 2 hours? ① Yes ② No	① ②
8	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

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[Annex No. 5-6] For 54~60 months

Health checkup questionnaire for infants (For 54~60 months)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: Year Month Day
2. Birth weight: . kg (round off to the nearest tenth)
3. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio)	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									

4. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Does the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	①	②

Accident preventative education

		Yes ①	No ②
1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.??	①	②
2	Does your child play on the road where cars are passing by?	①	②
3	Do you put your child in a booster seat and fasten his/her seat belt when you take him for a ride in a car?(If you do not have a car ③)	①	② ③
4	Does the child know the rules he/she has to observe in a pool?	①	②
5	Does the child play with matches, lighters, or fireworks?	①	②
6	Do you keep drugs, chemical agents (bleach, detergent, etc.), and sharp objects out of reach of children?	①	②

Auditory sense

		Yes ①	No②
1	Is the child able to answer the questions after listening to a simple fairytale or story?	①	②
2	Is the child able to communicate naturally with other people using simple sentences?	①	②
3	Is the child able to understand and follow a command composed of two different actions? (Pick up the book, and put it in a bag.)	①	②
4	Is the child able to talk about happenings in a kindergarten, playground, a friend's house, etc.?	①	②
5	Is the child able to use words that include consonants such as s, th, j, ch, etc.?	①	②

Personal hygiene education

		Yes ①	No ②
1	Does the child wash his/her hands before eating?	①	②
2	Does the child wash his/her hands after touching toys or animals?	①	②
3	Does the child wash his/her hands after using the toilet?	①	②
4	Does the child frequently touch his/her eyes, nose, or mouth with his/her hands?	①	②
5	How do you manage when the child cannot use water to wash the hands outside? ① Clean them with dry tissue. ② Clean them with wipes. ③ Use a hand sanitizer containing alcohol. ④ Leave it just as it is.	① ② ③	② ④

Nutrition education

1	How do you think of the child's appearance (size)? ① Kind of fat ② Middle ③ Kind of skinny	① ② ③
2	Does the child eat at a similar pace with other family members? ① Faster ② Similar ③ Slower	① ② ③
3	Does the child regularly have meals and snacks? ① Yes ② No	① ②
4	How is the amount the child eats at a time when compared to kids in his/her age group? ① Less ② Similar ③ More	① ② ③
5	Does the child only eat what he/she wants to? ① Yes ② No	① ②
6	Does the child eat greasy, sweet, or salty food a lot? (e.g., Fast food, precooked food, etc.) ① Yes ② No	① ②
7	Does the child prefer drinks other than water? ① Yes ② No	① ②
8	Does your child watch TV or is exposed to the monitor (computer, game console, smartphone, etc.) for over 2 hours? ① Yes ② No	① ②
9	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

210㎜×297㎜[일반용지 60g/㎡ (재활용품)]

[Annex No. 5-7] For 66~71 months ●○

Health checkup questionnaire for infants (For 66–71 months)

Subject name		Resident registration number		Telephone of guardian	
Name of guardian		Relationship to the subject		E-mail address	

※ Do you agree to receive health-related information and project information provided by the National Health Insurance Corporation or public health center via an e-mail or post? Yes□ No□

※ If you receive a health checkup exceeding the predetermined number, the corresponding cost will be retrieved from you as unjust enrichment.

1. Date of birth of child: ____ Year ____ Month ____ Day

2. Birth weight: ☐☐.☐ kg (round off to the nearest tenth)

3. Please check the vaccinations completed so far. (Please indicate the frequency of the corresponding box.)

	BCG	Hepatitis B	DPT	Poliomyelitis (polio))	Pneumococcus	Haemophilus B	Measles, mumps, rubella	Chickenpox	Japanese encephalitis
Numbers completed									

4. Has your baby been diagnosed with a development problem, or does he/she have a disease currently undergoing treatment? ①Yes ② No If you answer "yes," what is the specific diagnosis? _____

Vision

		Yes ①	No ②
1	Does the position of the pupil of the baby seem strange?	①	②
2	Does the baby turn his/her head and turn sideways to see forward (objects in front of him/her) or does he/she look with his/her head tilted?	①	②
3	Does your baby read a book / watch TV / see things at a very close distance or frown to see?	①	②
4	Does the visual acuity of each eye of your child seem different when comparing each eye when you make him/her to see as covering each eye?	①	②

Accident preventative education

		Yes ①	No ②
1	Does the child always wear a helmet and joint protection equipment when riding a bicycle, wearing inline skates, etc.?	①	②
2	Has the child ever crossed the road alone?	①	②
3	Do you put your child in a booster seat and fasten his/her seat belt when you take him for a ride in a car?(If you do not have a car ③)	①	② ③
4	Does the child know the phone number to report to in case of fire?	①	②
5	Do you allow the child to play in a playground alone for you to perform other activities?	①	②

Auditory sense

		Yes ①	No ②
1	Is the child able to pronounce the majority of the vowels and consonants correctly?	①	②
2	Does the child understand well when being told in a small voice?	①	②
3	Does the child easily communicate with other people verbally?	①	②
4	Is the child able to repeat exactly what an adult says?	①	②
5	Is there any relative or parent who has a hearing impairment since childhood?	①	②

Preschool readiness education

		Yes ①	No ②
1	Is the child able to distinguish the good and bad behaviors by him/herself?	①	②
2	Is the child able to wait for things he/she wants to do, to eat, and to have?	①	②
3	Does the child play along with other kids well? (e.g.: Is the child able to make compromises when playing with his/her friends?)	①	②
4	Is the child able to sit at one place during a lesson in a nursery or kindergarten?	①	②
5	Is the child able to follow the instructions of an adult and rules provided by parents or teachers?	①	②
6	Is it hard for the child to separate from his/her parents when going to kindergarten?	①	②
7	Is the child able to manage to go to a toilet by him/herself?	①	②
8	Is the child able to ask for help from other people when necessary?	①	②
9	Does the child wake up and go to bed at a regular time?	①	②

Nutrition education

1	Does the child tend to have his/her breakfast? ① Yes ② Not every day but generally ③ No	① ② ③
2	How many dinners does the family have together in a week? ① 1–2 times ② 3–4 times ③ More than 5 times	① ② ③
3	Does the child often eat dairy products containing calcium (such as milk, plain yogurt, cheese, etc.)? ① Yes ② No	① ②
4	When does the child have a snack? ① He/she does not have a snack. ② Between meals ③ Before going to bed or late at night ④ Whenever he/she wants	① ② ③ ④
5	What kind of food does he/she mainly eat as a snack? (Please check all corresponding numbers if applicable.) ① Sugar-added beverage (e.g.: Carbonated drink, sports drink, kids' drink, etc.) ② Greasy, sweet, or salty food (e.g.: Fast food, precooked food, etc.) ③ Not applicable	① ② ③
6	Does your child perform vigorous physical activities (playing, exercise, etc.) for over 1 hour a day? ① Yes ② No	① ②

210㎜×297㎜[일반용지 60g/㎡ (재활용품)]

[Annex No. 6]

Infant/Toddler Dental Health Screening Program

(This screening program is for 18–29 months of age.)

Examinee's name		ID No.		Telephone	
				Mobile phone	
Parent's/guardian's name		ID No.		Relation	
□ Health insurance subscriber □ Medicaid recipient				E-mail	
Address				Zip code	-

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

Infant/toddler dental health examinations are available at **2 years old (18–29 months), 4 years old (42–53 months), and 5 years old (54–65 months). Each examination consisted of tests suitable for developmental stage.**

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

※ These are questions about dental history and awareness about the oral health of your child.

1. Have you brought your child to dental clinic since his/her birth? ① Yes ② No
2. Has your child told you about his/her toothache? ① Yes ② No
3. Do you think your child currently has cavity? ① Yes ② No ③ I do not know

※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride).

4. Does your child stop bottle of milk? ① yes ② no
5. How often does your child eat 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
6. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?
   ① Never ② Once ③ 2–3 times ④ More than 4 times ⑤ I do not know
7. Have you learned how to brush your child's teeth from a dental clinic or health center?
   ① Yes ② No
8. Do you regularly brush your child's teeth? ① Yes ② No
9. How many times does your child brush his/her teeth in a regular day or how many times do you brush your child's teeth?
   ① Less than once a week ② At least once a week but not every day
   ③ Once a day ④ Twice a day ⑤ More than 3 times a day
10. Has your child started using toothpaste? ① Yes ② No
11. Does your child's toothpaste contain fluoride?
    ① Yes ② No ③ I do not know ④ He or she does not use toothpaste
12. How much toothpaste is used in every brush?
    ① Very little ② Size of a small bean ③ Half the length of the head of a toothbrush
    ④ As long as the head of a toothbrush ⑤ He or she does not use toothpaste

※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.

[Annex No.6-2]

Infant/Toddler Dental Health Screening Program

(This screening program is for 42–53 months of age.)

Examinee's name		ID No.		Telephone	
				Mobile phone	
Parent's/guardian's name		ID No.		Relation	
□ Health insurance subscriber □ Medicaid recipient				E-mail	
Address				Zip code	-

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

Infant/toddler dental health examinations are available at **2 years old (18–29 months), 4 years old (42–53 months), and 5 years old (54–65 months). Each examination consisted of tests suitable for developmental stage.**

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

※ These are questions about dental history and awareness about oral health of your child

1. Have you brought your child to a dental clinic in the last year? ① Yes ② No
2. Has your child told you about his/her toothache? ① Yes ② No
3. Do you think your child currently has cavity? ① Yes ② No ③ I do not know

※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride)

4. How often does your child eat 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

5. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?
   ① Never ② Once ③ 2–3 times ④ More than 4 times ⑤ I do not know

6. Has your child learned how to brush his/her teeth from a dental clinic or health center?
   ① Yes ② No

7. Do you regularly brush your child's teeth? ① Yes ② No

8. Please select all occasions in which your child brushes his/her teeth.
   ① Before breakfast ② After breakfast ③ Before lunch ④ After lunch ⑤ Before going to bed
   ⑥ After a snack

9. Does your child's toothpaste contain fluoride?
   ① Yes ② No ③ I do not know ④ He or she does not use toothpaste

10. How much toothpaste is used in every brush?
    ① Very little ② Size of a small bean ③ Half the length of the head of a toothbrush
    ④ As long as the head of a toothbrush ⑤ He or she does not use toothpaste

11. Have you ever been advised about using fluoride to prevent cavity of your child?
    ① Yes ② No

※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.

[Annex No.6-3]

Infant/Toddler Dental Health Screening Program

(This screening program is for 54–65 months of age.)

Examinee's name		ID No.		Telephone	
				Mobile phone	
Parent's/guardian's name		ID No.		Relation	
□ Health insurance subscriber □ Medicaid recipient				E-mail	
Address				Zip code	-

※ Do you agree to receive health information or notices from the National Health Insurance Service (NHIS) and/or health centers by letter or e-mail? (please check ☑) Yes □ No □

Infant/toddler dental health examinations are available at **2 years old (18–29 months), 4 years old (42–53 months), and 5 years old (54–65 months). Each examination consisted of tests suitable for developmental stage.**

This screening test is to collect information about your child before the examination and very important for evaluating the dental health of your child. All information provided are confidential and, therefore, please answer all questions with honesty and to the best of your knowledge. Parents or legal guardians should answer this questionnaire. If you are unsure, please carefully observe your child before answering.

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

1. Have you brought your child to dental clinic in the last year? ① Yes ② No

2. Has your child told you about his/her toothache? ① Yes ② No

3. Do you think your child currently has cavity? ① Yes ② No ③ I do not know

※ These are questions about your child's oral health habits (sugar intake, oral hygiene, and use of fluoride)

4. How often does your child eat 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

5. How many times does your child drink soda or sweet drinks (including sports drink, ion supply drink, and fruit juice)?
① Never ② Once ③ 2–3 times ④ More than 4 times ⑤ I do not know

6. Has your child learned how to brush his/her teeth from a dental clinic or health center?
① Yes ② No

7. Do you regularly brush your child's teeth? ① Yes ② No

8. Please select all occasions in which your child brushes his/her teeth.
① Before breakfast ② After breakfast ③ Before lunch ④ After lunch ⑤ Before going to bed ⑥ After a snack

9. Does your child's toothpaste contain fluoride?
① Yes ② No ③ I do not know ④ He or she does not use toothpaste

10. How much toothpaste is used in every brush?
① Very little ② Size of a small bean ③ Half the length of the head of a toothbrush
④ As long as the head of a toothbrush ⑤ He or she does not use toothpaste

11. Have you ever been advised about using fluoride to prevent cavity of your child?
① Yes ② No

※ Please write any question(s) to ask or describe if your child has a special condition that needs a doctor's attention.

210 ㎜ × 297 ㎜ [백상지 80 g/㎡]

[Annex No. 14] For 4~6 months ●○

Health checkup result report for infants (for 4–6 months old)

Subject name		Resident registration number	

Body measuring	Height (cm)	Body weight (kg)	Head circumference (cm)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐kg (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required

* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.

Physical examination impression						
	General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
	Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
	Head/face (Checking fontanel)	☐ Good	☐ Abnormal	Heart (Checking for heart murmurs)	☐ Good	☐ Abnormal
	Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
	Nose	☐ Good	☐ Abnormal	Genitals (Undescended or hydrocele testis)	☐ Good	☐ Abnormal
	Ears (Auricular, external auditory meatus malformation)	☐ Good	☐ Abnormal	Extremities (Checking for dislocation of hip joints)	☐ Good	☐ Abnormal
	Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
	Neck (Checking for muscular torticollis)	☐ Good	☐ Abnormal	Neurological examination (Checking muscle tone, primitive reflex)	☐ Good	☐ Abnormal

Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related ☐ 1 ☐ 2 ☐ 3 ☐ 4] to the condition:
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6] to the condition:
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Education for prevention of sudden infant death syndrome
General determination		☐ Good ☐ Caution ☐ Further evaluation required
Impression and actions taken		

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.
* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.
* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.
* It is helpful to bring your result report of this time for your next checkup.

210㎜×297㎜[일반용지 60g/㎡ (재활용품)(또는 NCR 2P) 60g/m²]

[Annex No. 14-2] For 9~12 months ●○

Health checkup result report for infants (for 9–12 months old)

Subject name		Resident registration number	

Body measurement	Height (cm)	Body weight (kg)	Head circumference (cm)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐kg (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required

* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.

Impression of physical examination						
	General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
	Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
	Head/face	☐ Good	☐ Abnormal	Heart (Checking for heart murmurs)	☐ Good	☐ Abnormal
	Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
	Nose	☐ Good	☐ Abnormal	Genitals (Undescended or hydrocele testis)	☐ Good	☐ Abnormal
	Ears (Auricular, external auditory meatus malformation)	☐ Good	☐ Abnormal	Extremities (Checking for dislocation of hip joints)	☐ Good	☐ Abnormal
	Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
	Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal

Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4]
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Oral health education
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] [Regarding additional questions ☐ Motor development(M)] ☐ Continuous management required
General determination		☐ Good ☐ Caution ☐ Further evaluation required
Impression and actions taken		

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.
* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.
* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.
* It is helpful to bring your result report of this time for your next checkup.

210㎜×297㎜[일반용지 60g/㎡ (재활용품)(또는 NCR 2P) 60g/m^2]

[Annex No. 14-3] For 18~24 months ●○

Health checkup result report for infants (For 18~24 months)

Subject name				Resident registration number		
Body measurement	Height (cm)		Body weight (kg)		Head circumference cm)	
	☐ ☐. ☐ cm (Percentile)		☐ ☐. ☐kg (Percentile)		☐ ☐. ☐ cm (Percentile)	
	☐ Good ☐ Further evaluation required		☐ Good ☐ Further evaluation required		☐ Good ☐ Further evaluation required	
	* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.					
Impression of physical examination	General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
	Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
	Head/face	☐ Good	☐ Abnormal	Heart	☐ Good	☐ Abnormal
	Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
	Nose	☐ Good	☐ Abnormal	Genitals	☐ Good	☐ Abnormal
	Ears	☐ Good	☐ Abnormal	Extremities	☐ Good	☐ Abnormal
	Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
	Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal
Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4]				
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]				
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Toilet training				
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] [Regarding additional questions ☐ Motor development(M)] ☐ Language development (L) ☐ Social skill development (S)] ☐ Continuous management required				
General determination		☐ Good ☐ Caution ☐ Further evaluation required				
Impression and actions taken						
Medical institution number		Name of health checkup institution				
examination		License number		Name of doctor	(signature)	

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.
* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.
* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.
* It is helpful to bring your result report of this time for your next checkup.

210㎜×297㎜[일반용지 60g/㎡ (재활용품)(또는 NCR 2P) 60g/m^2]

[Annex No. 14-4] For 30~36 months ●○

Health checkup result report for infants (For 30~36 months)

Subject name		Resident registration number	

Body measurement	Height (cm)	Body weight (kg)	Head circumference cm)	BMI(kg/㎡)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ kg (Percentile)	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required

* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.

Impression of physical examination						
General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
Head/face	☐ Good	☐ Abnormal	Heart	☐ Good	☐ Abnormal
Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
Nose	☐ Good	☐ Abnormal	Genitals	☐ Good	☐ Abnormal
Ears	☐ Good	☐ Abnormal	Extremities	☐ Good	☐ Abnormal
Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal

Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4]
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Oral health education
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill ☐ Self-help] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill ☐ Self-help] [Regarding additional questions ☐ Motor development(M) ☐ Language development (L) ☐ Social skill development (S)] ☐ Continuous management required
General determination		☐ Good ☐ Caution ☐ Further evaluation required
Impression and actions taken		

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.

* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

* It is helpful to bring your result report of this time for your next checkup.

210㎜×297㎜[일반용지 60g/㎡ (재활용품)(또는 NCR 2P) 60g/m^2]

[Annex No. 14-5] For 42~48 months ●○

Health checkup result report for infants (for 42-48 months old)

Subject name		Resident registration number	

Body measuring	Height (cm)	Body weight (kg)	Head circumference cm)	BMI(kg/㎡)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ kg (Percentile)	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required

* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.

Physical examination impression						
General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
Head/face	☐ Good	☐ Abnormal	Heart	☐ Good	☐ Abnormal
Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
Nose	☐ Good	☐ Abnormal	Genitals	☐ Good	☐ Abnormal
Ears	☐ Good	☐ Abnormal	Extremities	☐ Good	☐ Abnormal
Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal

Vision			
	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4]	
	Visual acuity test	☐ Picture eye chart ☐ Number eye chart ☐ Good ☐ Further evaluation required ☐ Not able to follow the test	Left eye: Right eye:
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]	
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Emotion and sociality education	
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] [Regarding additional questions ☐ Motor development(M)] ☐ Language development (L) ☐ Continuous management required	
General determination		☐ Good ☐ Caution ☐ Further evaluation required	
Impression and actions taken			

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.

* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

* It is helpful to bring your result report of this time for your next checkup.

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[Annex No. 14-6] For 54~60 months ●○

Health checkup result report for infants (for 54–60 months old)

Subject name			Resident registration number	
Body measuring	Height (cm)	Body weight (kg)	Head circumference cm)	BMI(kg/㎡)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ kg (Percentile)	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required
	* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.			

Physical examination impression	General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
	Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
	Head/face	☐ Good	☐ Abnormal	Heart	☐ Good	☐ Abnormal
	Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
	Nose	☐ Good	☐ Abnormal	Genitals	☐ Good	☐ Abnormal
	Ears	☐ Good	☐ Abnormal	Extremities	☐ Good	☐ Abnormal
	Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
	Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal

Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4]	
	Visual acuity test	☐ Picture eye chart ☐ Number eye chart ☐ Good ☐ Further evaluation required ☐ Not able to follow the test	Left eye: Right eye:
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]	
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Personal hygiene education	
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] [Regarding additional questions ☐ Social skill development (S)] ☐ Continuous management required	
General determination		☐ Good ☐ Caution ☐ Further evaluation required	
Impression and actions taken			

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.
* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.
* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.
* It is helpful to bring your result report of this time for your next checkup.

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[Annex No. 14-7] For 66~71 months ●○

Health checkup result report for infants (for 66–71 months old)

Subject name			Resident registration number	

Body Measurement	Height (cm)	Body weight (kg)	Head circumference cm)	BMI(kg/㎡)
	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ kg (Percentile)	☐ ☐. ☐ cm (Percentile)	☐ ☐. ☐ cm (Percentile)
	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required	☐ Good ☐ Further evaluation required

* Percentile refers to an order from the smallest among 100 infants with the same sex and age. The developmental curve of the graphs above indicates percentile of 5, 10, 25, 50, 75, 90, and 95 from the bottom to top, respectively.

Physical examination impression						
General status	☐ Good	☐ Abnormal	Chest	☐ Good	☐ Abnormal
Skin	☐ Good	☐ Abnormal	Lungs	☐ Good	☐ Abnormal
Head/face	☐ Good	☐ Abnormal	Heart	☐ Good	☐ Abnormal
Eyes	☐ Good	☐ Abnormal	Abdomen	☐ Good	☐ Abnormal
Nose	☐ Good	☐ Abnormal	Genitals	☐ Good	☐ Abnormal
Ears	☐ Good	☐ Abnormal	Extremities	☐ Good	☐ Abnormal
Oral	☐ Good	☐ Abnormal	Spinal	☐ Good	☐ Abnormal
Neck	☐ Good	☐ Abnormal	Neurological test	☐ Good	☐ Abnormal

Vision	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition ☐ 1 ☐ 2 ☐ 3 ☐ 4]	
	Visual acuity test	☐ Picture eye chart ☐ Number eye chart ☐ Good ☐ Further evaluation required ☐ Not able to follow the test	Left eye: Right eye:
Auditory sense	Questionnaire	☐ Good ☐ Further evaluation required [Questionnaires related to the condition ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Regarding K-DST]	
Conducting health education		☐ Accident preventative education ☐ Nutritional education ☐ Personal hygiene education	
Result of development evaluation		☐ Good ☐ Follow-up examination required [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] ☐ Further evaluation recommended [☐ Gross motor exercise ☐ Fine motor exercise ☐ Cognition ☐ Language ☐ Social skill] ☐ Self-help] [Regarding additional questions ☐ Social skill development (S)] ☐ Continuous management required	
General determination		☐ Good ☐ Caution ☐ Further evaluation required	
Impression and actions taken			

Medical institution number		Name of health checkup institution			
examination		License number		Name of doctor	(signature)

* In case of a certain disease with low prevalence, it might not be detected by the health checkup.

* Even if the result of a health checkup is determined as Good, please keep the continuous effort to maintain a good state of health, and if the result is determined as “Caution” or “Further evaluation required,” please consult your doctor.

* If the doctor’s impression in which the subject needs medical care is stated on the notification letter of the health checkup result, the notification letter can serve as a medical care referral (treatment referral) for treatment at a more advanced hospital.

* It is helpful to bring your result report of this time for your next checkup.

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[Annex No. 15]

Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 18 months to 29 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

Screening test results					
(Dental) medical history	□ No □ Yes	Oral health habits	Sugar intake	□ No	□ Yes
			Oral hygiene	□ No	□ Yes
Awareness about oral health	□ No □ Yes		Use of fluoride	□ No	□ Yes

Oral examination results

Section	Disease	List	Results	Note
Tooth test	Dental caries (cavity)	Teeth condition		

55	54	53	52	51	61	62	63	64	65
85	84	83	82	81	71	72	73	74	75

Indication	Cavity ●	Cavity suspected ◑	Repaired F	

Dental caries	□ **No** □ **Yes**	※ Milk tooth caries incident rate (2006/%)
Proximal caries suspected tooth	□ **No** □ **Yes**	(Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007)
Repaired tooth	□ **No** □ **Yes**	※ List of examination ① Dental caries: tooth with cavity. ② Proximal caries suspected tooth: Interdental cavity suspected tooth. ③ Repaired tooth: Tooth repaired by capping with gold, resin, or amalgam to remedy cavity.

	Total	Boy	Girl
2 yrs	13	9	32
3 yrs	27	15	23

Examination of other parts			
Dental health test	**Dental caries**	**Residual food and dental plaque**	□ Excellent □ Fair □ Needs improvement

Results and Recommendation

Results		□ **Normal A** □ **Normal B** □ **Observe caution** □ **Needs treatment**	
Recommendation	Dental health education needed	Follow-up management required	Additional recommendation
	□ Sugar intake (nutrition) □ Oral hygiene □ Use fluoride	□ Detailed oral examination (e.g., radiation test, etc.) □ Professional oral hygiene needed. □ Special prevention (filling, coating fluoride, etc.) □ Oral disease treatment (dental caries, etc.)	
Explanation of results			

Dental institution code		Examining clinic		Examining dentist	(signature)
Examination date	(year) (month) (date)			License No.	

※ This dental health screening is designed to detect and treat cavities. Therefore, not all diseases can be identified from this screening. It is advised to consult with a dentist as recommended.

[Annex No. 15-2]

Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 42 months to 53 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

Screening test results					
(Dental) medical history	□ No □ Yes	Oral health habits	Sugar intake	□ No	□ Yes
Awareness about oral health	□ No □ Yes		Oral hygiene	□ No	□ Yes
			Use of fluoride	□ No	□ Yes

Oral examination results

Section	Disease	List	Results	Note
Tooth test	Dental caries (cavity)	Teeth condition		

16	55	54	53	52	51	61	62	63	64	65	26
46	85	84	83	82	81	71	72	73	74	75	36

Indication Cavity ● Cavity suspected ◑ Repaired F Filling Se

Dental caries	□ **No** □ **Yes**	※ Milk tooth caries incident rate (2006/%)
Proximal caries suspected tooth	□ **No** □ **Yes**	
Repaired tooth	□ **No** □ **Yes**	※ List of examination
Tooth at risk of caries	□ **No** □ **Yes**	

	Total	Boy	Girl
2 yrs	13	9	32
3 yrs	27	15	23

(Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007)

① Dental caries: tooth with cavity.
② Proximal caries suspected tooth: Interdental cavity suspected tooth.
③ Repaired tooth: Tooth repaired by capping with gold, resin, or amalgam to remedy cavity.

Examination of other parts				
Dental health test	**Dental caries**	**Residual food and dental plaque**	□ **Excellent** □ **Fair** □ **Needs improvement**	

Results and Recommendation

Results		□ **Normal A** □ **Normal B** □ **Observe caution** □ **Needs treatment**	
Recommendation	Dental health education needed	Follow-up management required	Additional recommendation
	□ Sugar intake(nutrition) □ Oral hygiene □ Use fluoride	□ Detailed oral examination (e.g., radiation test, etc.) □ Professional oral hygiene needed. □ Special prevention (filling, coating fluoride, etc.) □ Oral disease treatment (dental caries, etc.)	
Explanation of results			

Dental institution code		Examining clinic		Examining dentist	(signature)
Examination date	(year)	(month)	(date)	License No.	

※ This dental health screening is designed to detect and treat cavities. Therefore, not all diseases can be identified from this screening. It is advised to consult with a dentist as recommended.

[Annex No. 15-3]

Results of Infant/Toddler Dental Health Screening

(This result is for infants/toddlers between 54 months to 65 months of age.)

Name		Residential ID No.	- 3(4)
Address		Contact information	

Screening test results					
(Dental) medical history	□ No □ Yes	Oral health habits	Sugar intake	□ No	□ Yes
Awareness about oral health	□ No □ Yes		Oral hygiene	□ No	□ Yes
			Use of fluoride	□ No	□ Yes

Oral examination results

Section	Disease	List	Results	Note
Tooth test	Dental caries (cavity)	Teeth condition		

				12	11	21	22					
16	55	54	53	52	51	61	62	63	64	65	26	
46	85	84	83	82	81	71	72	73	74	75	36	
				42	41	31	32					

Indication: Cavity ● Cavity suspected ◑ Repaired F Filling Se

Dental caries	□ No	□ Yes
Proximal caries suspected tooth	□ No	□ Yes
Repaired tooth	□ No	□ Yes
Tooth at risk of caries	□ No	□ Yes

※ Milk tooth caries incident rate (2006/%)

	Total	Boy	Girl
2 yrs	13	9	32
3 yrs	27	15	23

(Ministry of Health and Welfare. 2006 National Oral Health Survey data in 2007)

※ List of examination

① Dental caries: tooth with cavity.
② Proximal caries suspected tooth: Interdental cavity suspected tooth.
③ Repaired tooth: Tooth repaired by capping with gold, resin, or amalgam to remedy cavity.
④ Tooth at risk of caries: Tooth with high risk of decay, of which cavities are need to be filled.

Examination of other parts			
Dental health test	Dental caries	Residual food and dental plaque	□ Excellent □ Fair □ Needs improvement

Results and Recommendation

Results	□ Normal A □ Normal B □ Observe caution □ Needs treatment		
Recommendation	Dental health education needed	Follow-up management required	Additional recommendation
	□ Sugar intake (nutrition) □ Oral hygiene □ Use fluoride	□ Detailed oral examination (e.g., radiation test, etc.) □ Professional oral hygiene needed. □ Special prevention (filling, coating fluoride, etc.) □ Oral disease treatment (dental caries, etc.)	
Explanation of results			

Dental institution code		Examining clinic		Examining dentist	(signature)
Examination date	(year)	(month)	(date)	License No.	

※ This dental health screening is designed to detect and treat cavities. Therefore, not all diseases can be identified from this screening. It is advised to consult with a dentist as recommended.

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210 ㎜ × 297 ㎜ [백상지 80 g/㎡ 또는 NCR 2P 60 g/㎡]

<A front cover>

The guidance of a health screening program
Health Screening Program Information_English
Health Screening Program Information_Chinese
Health Screening Program Information_Japanese
Health Screening Program Information_Vietnamese
Health Screening Program Information_Philippines(Tagalog)
Health Screening Program Information_Thai
Health Screening Program Information_O‘zbektili
Health Screening Program Information_Mongolian
Health Screening Program Information_Cambodian
Health Screening Program Information_Nepali
Health Screening Program Information_Indonesian
Health Screening Program Information_Sinhala

“From infancy until the prevention of presbyophrenia, for early detection of diseases with a lifetime of health screenings, we will promote public health and protect life.”

Ministry of Health & Welfare,
National Health Insurance Service

【 The guidance of health screening program 】

NHIS holds a health checkup project for the purpose of maintaining people's health for health insurance policyholders and Medicaid recipients through the prevention and early detection of diseases.

♠ **The general health screening** aims for the prevention and early detection of cardiovascular and cerebrovascular disease, such as hypertension and diabetes. The screening targets individuals above 40 years old and it shall be conducted once every 2 years. However, there are no age limits for those who are local members with a householder and working members and it shall be conducted once every year for those who are working members with nonoffice work experience.

♠ **The health screening of transition period of lifetime** targets people aged 40 and 66 years old for the basic examination of general screening, adjustment examination for each age (B hepatitis tests, bone density testing, mental health screenings, etc.), lifestyle assessment, and consultation with a doctor for the examination result.

♠ **An oral checkup** is conducted for the early detection of oral diseases, such as dental caries, periodontal diseases, and so on, for the subjects of the general health checkup and the lifetime transition period health checkup.

♠ **Cancer screening** focuses on 5 major cancers that have a high-risk rate and can be detected and cured in a simple way. The data gathered so far shows that gastric and breast cancer are seen in individuals over 40 years old, colon cancer in individuals over 50, cervical cancer in women over 30, and liver cancer in individuals over 40, and specifically, among the group with hepatocarcinogenic potential. The examination period shall be conducted once every 2 years for gastric cancer, breast cancer, and cervical cancer, and once every year for colon and liver cancers.

♠ **The infant health screenings** include the required examinations for normal healthy growth, including growth and development assessments and infant care consultations reflecting health education. The qualifying candidates may obtain up to 10 screenings, for children under 6 years old at 4, 9, 18, 30, 42, 54, and 66 months of age, including a dental exam.

【The cost of health screening】

- ♠ The costs of general health screenings, the health screening of transition period of lifetime, and the infants' health screening shall be borne fully by the corporation. Therefore, no extra cost shall be borne by the examinee during the examination**.**
- ♠ Regarding the cancer screening, 90% of the screening cost shall be borne by the corporation and the remaining 10% shall be borne by the examinee. However, regarding the cervical cancer screening, it shall be borne fully by the corporation.
- ♠ Regarding the screening cost of the national cancer screening subject (write on the screening table to the standard of insurance premium), it shall be borne by the country for 10% of the cost of burden for the examinee, so no cost shall be borne by the examinee.

【The procedure of health screening】

- ♠ Check health screening subject
  Check the screening event and screening item by the screening confirmation dispatched (residence or working place) to the screening subject from the corporation.
- ♠ Appointment and visiting the health screening agency
  You can schedule a health screening test in ANY AUTHORIZED hospital regardless of the area you are residing in. Please bring your ID and Medical Checkup Card on your appointment.
- ♠ Notification of the screening result
  The screening result shall be mailed to the contact information of the examinee by the screening agency in the place where the screening took place. A person with a suspected disease from the 1st screening will be informed about the 2nd screening. After the 1st screening result, the 2nd screening conduct shall be shown.

【Precautions during the health screening】

- ♠ You have to fast after 9:00 p.m. on the day before the health screening
  - Should undergo fasting for at least 8 hours.
  - The screening result may not be accurate if subject is not in a fasting state.
- ♠ Please avoid screening during menstruation (about 2–3 days before and after menstruation).
- ♠ The health screening can be received only with fixed numbers and in case of receiving in excess of the numbers, the screening cost shall be returned.

<Back side>

【9 tips for preventing cardiovascular and cerebrovascular disease 】

<Reference: Ministry of Health & Welfare>

1_Discontinue smoking.
2_Reduce the consumption of alcohol to 1 or 2 glasses per day.
3_Maintain a healthy diet and eat plenty of vegetables and fish.
4_Try to exercise more than 30 minutes a day whenever possible.
5_Maintain proper weight. Regularly take waist measurements.
6_Find ways to reduce stress and enjoy life.
7_Measure blood pressure periodically and check blood sugar and cholesterol.
8_Reduce and cure hypertension, diabetes, and hyperlipidemia.
9_Note the symptoms of stroke and transmural myocardial infarction, and in the event of an emergency, seek immediate medical attention.

【The Web page of the National Health Insurance Corporation with foreign languages】

- ☞ **http://www.nhis.or.kr/english/**
- ☞ **http://www.nhis.or.kr/japanese/**
- ☞ **http://www.nhis.or.kr/chinese/**
- ☞ **http://www.nhis.or.kr/vietnamese/**

【English call center of the National Health Insurance service】☎ 02-390-2000