

内

国民年金  
厚生年金保険

診 断 書

腎疾患・肝疾患  
糖尿病 の障害用

|   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|---|--------------------|--|--|-------------------|---|------------------------------------|--|-------|--|-----|--|--|--|--|------|--|--|--|--|------------|--|--|--|--|-----|--|--|--|--|-----|-----|--|--|--|-----|--|--|--|----|--|--|--|----------------------------|--|--|--|---------------|--|--|--|-----------|--|--|--|-----------|--|--|--|-----------------------------|--|--|--|------------|--|--|--|--------------|--|--|--|----------------|--|--|--|-------------------|--|--|--|------------------|--|--|--|-----------------------|--|--|--|--------|--|--|--|
| (フリガナ)<br>氏 名   |                    | 生年月日   |  | 昭和 平成 年 月 日生 ( 歳) |   | 性別                                 |  | 男・女   |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 住 所   |                    | 住所地の郵便番号                                       |  | 都道府県              |   | 郡市区                                |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ① 障害の原因<br>となった<br>傷病名  |                    | ② 傷病の発生日                                       |  | 昭和 平成 年 月 日       |   | 診 療 録 で 確 認 して<br>( 年 月 日 ) 本人の申立て |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   |                    | ③ ①のため初めて医師<br>の診療を受けた日                        |  | 昭和 平成 年 月 日       |   | 診 療 録 で 確 認 して<br>( 年 月 日 ) 本人の申立て |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ④ 傷病の原因<br>または誘因  |                    | 初診年月日(昭和・平成 年 月 日)                             |  | ⑤ 既存<br>障害        |   | ⑥ 既往症                              |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑦ 傷病が治った(症状が固定して治療<br>の効果が期待できない状態を含む。)<br>かどうか                         |                    | 傷病が治っている場合                                     |  | 治った日 平成 年 月 日     |   | 確 認 推 定                            |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   |                    | 傷病が治っていない場合                                    |  | 症状のよくなる見込         |   | 有 ・ 無 ・ 不明                         |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑧ 診断書作成医療機関に<br>おける初診時所見<br>初診年月日<br>(昭和・平成 年 月 日)                      |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑨ 現在までの治療の内<br>容、期間、経過、その<br>他参考となる事項                                   |                    | 診療回数   |  | 年間 回、月平均 回        |   | 手術<br>手術名 ( )<br>手術年月日 ( 年 月 日)    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑩ 計 測<br>(平成 年 月 日計測)   |                    | 身長 cm  |  | 脈拍 回/分            |   | 最大 mmHg                            |  | 降圧薬服用 |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   |                    | 体重 kg  |  |                   |   | 最小 mmHg                            |  | 無・有   |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑪ 一 般 状 態 区 分 表 (平成 年 月 日) (該当するものを選んでどれか一つを○で囲んでください。)                 |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ア 無症状で社会活動ができ、制限を受けることなく、発病前と同等にふるまえるもの                                 |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| イ 軽度の症状があり、肉体労働は制限を受けるが、歩行、軽労働や座業はできるもの 例え、軽い家事、事務など                    |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ウ 歩行や身のまわりのことはできるが、時に少し介助が必要なもの、軽労働はできないが、日中の50%以上は起居しているもの             |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| エ 身のまわりのある程度のことはできるが、しばしば介助が必要で、日中の50%以上は就床しており、自力では屋外への外出等がほぼ不可能となったもの |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| オ 身のまわりのこともできず、常に介助を必要とし、終日就床を強いられ、活動の範囲がおおむねベッド周辺に限られるもの               |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 障 害 の 状 態   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ⑫ 腎 疾 患 (平成 年 月 日現症)  |                    | 腎性網膜症または糖尿病を合併する例では、糖尿病 (⑭) の欄にも必要事項を記入してください。 |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 1 臨床所見  |                    |  |  |                   | (3) 検査成績 (記入上の注意を参照)  |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (1) 自覚症状  |                    | (2) 他覚所見                                       |  |                   | <table border="1"> <tr> <td colspan="2">検査日</td> <td></td> <td></td> <td></td> </tr> <tr> <td>検査項目</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>尿蛋白一日量 g/日</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>尿蛋白</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td rowspan="3">尿沈渣</td> <td>赤血球</td> <td></td> <td></td> <td></td> </tr> <tr> <td>白血球</td> <td></td> <td></td> <td></td> </tr> <tr> <td>円柱</td> <td></td> <td></td> <td></td> </tr> <tr> <td>赤血球数 × 10<sup>4</sup>/μl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>ヘモグロビン濃度 g/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>ヘマトクリット %</td> <td></td> <td></td> <td></td> </tr> <tr> <td>白血球数 / μl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>血小板数 × 10<sup>4</sup>/ μl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>血清総蛋白 g/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>血清アルブミン g/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>総コレステロール mg/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>血液尿素窒素(BUN) mg/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>血清クレアチニン濃度 mg/dl</td> <td></td> <td></td> <td></td> </tr> <tr> <td>内因性クレアチニン・クリアランス ml/分</td> <td></td> <td></td> <td></td> </tr> <tr> <td>動脈血 ph</td> <td></td> <td></td> <td></td> </tr> </table> |                                    |  |       |  | 検査日 |  |  |  |  | 検査項目 |  |  |  |  | 尿蛋白一日量 g/日 |  |  |  |  | 尿蛋白 |  |  |  |  | 尿沈渣 | 赤血球 |  |  |  | 白血球 |  |  |  | 円柱 |  |  |  | 赤血球数 × 10 <sup>4</sup> /μl |  |  |  | ヘモグロビン濃度 g/dl |  |  |  | ヘマトクリット % |  |  |  | 白血球数 / μl |  |  |  | 血小板数 × 10 <sup>4</sup> / μl |  |  |  | 血清総蛋白 g/dl |  |  |  | 血清アルブミン g/dl |  |  |  | 総コレステロール mg/dl |  |  |  | 血液尿素窒素(BUN) mg/dl |  |  |  | 血清クレアチニン濃度 mg/dl |  |  |  | 内因性クレアチニン・クリアランス ml/分 |  |  |  | 動脈血 ph |  |  |  |
| 検査日   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 検査項目  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 尿蛋白一日量 g/日  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 尿蛋白   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 尿沈渣   | 赤血球                |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 白血球                |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 円柱                 |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 赤血球数 × 10 <sup>4</sup> /μl  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ヘモグロビン濃度 g/dl   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| ヘマトクリット %   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 白血球数 / μl   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 血小板数 × 10 <sup>4</sup> / μl   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 血清総蛋白 g/dl  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 血清アルブミン g/dl  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 総コレステロール mg/dl  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 血液尿素窒素(BUN) mg/dl   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 血清クレアチニン濃度 mg/dl  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 内因性クレアチニン・クリアランス ml/分   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 動脈血 ph  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 悪 心 (無・有・著)   | 浮 腫 (無・有・著)        |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 食 欲 不 振 (無・有・著)   | 意 識 障 害 (無・有・著)    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 頭 痛 (無・有・著)   | 尿毒症症状 (無・有・著)      |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | アチドージス (無・有・著)     |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 貧 血 (無・有・著)        |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 腎不全に基づく 神経症状 (無・有) |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 消化器症状 (無・有)        |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
|   | 視力障害 (無・有)         |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 2 腎生検 無・有   | 検査年月日(平成 年 月 日)    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 所見 [ ]  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 3 人工透析療法  |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (1)人工透析療法の実施の有無   |                    | 無・有 (CAPD、血液透析)                                |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (2)人工透析開始日  |                    | (平成 年 月 日)                                     |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (3)人工透析実施状況   |                    | 回数・ 回/週、 1回 時間                                 |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (4)人工透析導入後の臨床経過   |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| (5)長期透析による合併症   |                    | 無・有 (その所見 )                                    |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |
| 4 その他の所見 (腎臓移植術を行っているときは、その実施日を記入してください。)                               |                    |  |  |                   |   |                                    |  |       |  |     |  |  |  |  |      |  |  |  |  |            |  |  |  |  |     |  |  |  |  |     |     |  |  |  |     |  |  |  |    |  |  |  |                            |  |  |  |               |  |  |  |           |  |  |  |           |  |  |  |                             |  |  |  |            |  |  |  |              |  |  |  |                |  |  |  |                   |  |  |  |                  |  |  |  |                       |  |  |  |        |  |  |  |

「診療録で確認」または「本人の申立て」のどちらかを○で囲み、本人の申立ての場合は、それを聴取した年月日を記入してください。

(お願い) 太文字の欄は、記入漏れがないように記入してください。

(お願い) 臨床所見等は、診療録に基づいてわかる範囲で記入してください。

**障 害 の 状 態**

**⑬ 肝 疾 患 (平成 年 月 日現症)**

〔糖尿病または腎臓障害を合併する例では、糖尿病(⑭)、腎疾患(⑫)の欄にも必要事項を記入してください。〕

1 臨床所見

(1)自覚症状 (2)他覚所見

全身倦怠感 (無・有・著) 肝萎縮 (無・有・著)

発熱 (無・有・著) 脾腫大 (無・有・著)

食欲不振 (無・有・著) 浮腫 (無・有・著)

悪心・嘔吐 (無・有・著) 腹水 (無・有・有(難治性))

皮膚そう痒感 (無・有・著) 黄疸 (無・有・著)

有痛性筋痙攣 (無・有・著) 腹壁静脈怒張 (無・有・著)

吐血・下血 (無・有・著) 肝性脳症 (無・有(度))

出血傾向 (無・有・著)

2 Child-Pughによるgrade  
A (5・6) B (7・8・9) C (10・11・12以上)

3 肝生検 無・有 検査年月日(平成 年 月 日)  
所見 グレード ( ) ステージ ( )

4 食道・胃などの静脈瘤

(1)無・有 検査年月日(平成 年 月 日)

(2)吐血・下血の既往 無・有 ( 回)

(3)治療歴 無・有 ( 回)

5 ヘパトーマ治療歴 無・有

・手術 回 ・局所療法 回 ・動脈塞栓術 回

・放射線療法 回 ・化学療法 回

6 特発性細菌性腹膜炎その他肝硬変症に付随する病態の治療歴  
所見

7 治療の内容

(1)利尿剤 (無・有) (4)アルブミン・血漿製剤 (無・有)

(2)特殊アミノ酸製剤 (無・有) (5)血小板輸血 (無・有)

(3)抗ウイルス療法 (無・有) (6)その他

具体的内容

(3)検査成績 (記入上の注意を参照)

| 検査項目                  | 検査日                  | 施設基準値 | ・     | ・     | ・ |
|-----------------------|----------------------|-------|-------|-------|---|
| AST(GOT)              | IU/ℓ                 |       |       |       |   |
| ALT(GPT)              | IU/ℓ                 |       |       |       |   |
| γ-GTP                 | IU/ℓ                 |       |       |       |   |
| 血清総ビリルビン              | mg/dℓ                |       |       |       |   |
| アルカホスファターゼ'           | IU/ℓ                 |       |       |       |   |
| 血清総蛋白                 | g/dℓ                 |       |       |       |   |
| 血清アルブミン               | g/dℓ                 |       |       |       |   |
| BCG法・BCP法<br>・改良型BCP法 |                      |       |       |       |   |
| A/G比                  |                      |       |       |       |   |
| 血小板数                  | ×10 <sup>4</sup> /μℓ |       |       |       |   |
| プロトロンビン時間             | %                    |       |       |       |   |
| 総コレステロール              | mg/dℓ                |       |       |       |   |
| 血中アンモニア               | μg/dℓ                |       |       |       |   |
| AFP                   | ng/ml                |       |       |       |   |
| PIVKA-II              | mAU/ml               |       |       |       |   |
| アルコール性肝硬変の場合          | 180日以上アルコールを摂取していない。 | (○・×) | (○・×) | (○・×) |   |
|                       | 継続して必要な治療を実施している。    | (○・×) | (○・×) | (○・×) |   |

8 その他の所見

(1)肝移植 無・有 (有の場合は移植年月日(平成 年 月 日))  
経過

(2)その他(超音波・CT・MRI検査等) (平成 年 月 日)

**⑭ 糖 尿 病 (平成 年 月 日現症)** (腎合併症を認める例では、腎疾患(⑫)の欄に必要事項を記入してください。)

1 病 型 (いずれかの病型に○を付してください。)

(1)1型糖尿病 (2)2型糖尿病

(3)その他の型 (病名 )

2 ヘモグロビンA1cおよび空腹時血糖値の推移 (記入上の注意を参照)

| 検査項目           | 検査日 | 施設基準値 | ・ | ・ | ・ |
|----------------|-----|-------|---|---|---|
| HbA1c (%)      |     |       |   |   |   |
| 空腹時血糖値 (mg/dℓ) |     |       |   |   |   |

5 その他の所見

3 治療状況

(1)食事療法のみ (2)経口糖尿病薬による

(3)インスリンによる ( ・単位 / 日 回 / 日 )

4 合併症

(1)眼合併症 (平成 年 月 日)  
裸眼 矯正

ア 視 力 (右) \_\_\_\_\_  
(左) \_\_\_\_\_

イ 眼底所見

(2)神経障害 (症状・検査所見)

**⑮ その他の代謝疾患 (平成 年 月 日現症)**

(自覚症状・他覚所見・検査成績等)

⑯ 現症時の日常生活活動能力および労働能力 (必ず記入してください。)

⑰ 予 後 (必ず記入してください。)

⑱ 備 考

上記のとおり、診断します。 平成 年 月 日

病院または診療所の名称  
所 在 地

診療担当科名  
医師氏名 印