

School Name National Formosa University Student Health Examination Form  
 Ministry of Education, Taiwan, R.O.C. (Revised Version)

Student No.

Contact Information	Date of Entry	(yy)/(mm) /	Dept./Institute/Class				Name				
	Date of Birth	(yy)/(mm)/(dd) / /	Blood Type		Sex	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.				
	Permanent address							Cell phone No.		Attach photo here	
	Mailing address	If different from above:									
Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.						

Health Information	Medical History	Details of particular item/s or other matters requiring attention
	Please tick any of the following ailments you have had ( <i>please add details for 13. to 18.</i> ): <input type="checkbox"/> 1. None <input type="checkbox"/> 7. Epilepsy <input type="checkbox"/> 13. Psychological or mental illness: <input type="checkbox"/> 2. Tuberculosis <input type="checkbox"/> 8. SLE (Lupus) <input type="checkbox"/> 14. Cancer: <input type="checkbox"/> 3. Heart disease <input type="checkbox"/> 9. Hemophilia <input type="checkbox"/> 15. Thalassemia: <input type="checkbox"/> 4. Hepatitis <input type="checkbox"/> 10. G6PD deficiency <input type="checkbox"/> 16. Major surgery: <input type="checkbox"/> 5. Asthma <input type="checkbox"/> 11. Arthritis <input type="checkbox"/> 17. Allergy to: <input type="checkbox"/> 6. Kidney disease <input type="checkbox"/> 12. Diabetes mellitus <input type="checkbox"/> 18. Other:	<input type="checkbox"/> Details given in the attached file.
	<input type="checkbox"/> Holder of Catastrophic Illness Certificate - Category: <input type="checkbox"/> Holder of Physical/Mental Disability Manual - Category: Level: <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	
	If you are being treated for or recovering from any of the above or some other disease, please inform the medical personnel and also provide your medical records for the healthcare professionals' references.	
	Family medical history: relative with hereditary disease _____ Name of disease _____	

Lifestyle	※ Tick the box that best describes your lifestyle: 1. How much did you sleep during the past 7 days ( <i>not including weekends, or days off</i> )? <input type="checkbox"/> ① ≥ 7 hours a day <input type="checkbox"/> ② < 7 hours a day <input type="checkbox"/> ③ I suffer from insomnia 2. How many days did you eat breakfast during the past 7 days ( <i>not including weekends, or days off</i> )? <input type="checkbox"/> ① Never <input type="checkbox"/> ② Seldom: ___ days <input type="checkbox"/> ③ Every day at (time)? 3. During the past month ( <i>not including weekends, days off, or winter or summer vacation</i> ), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time? <input type="checkbox"/> ① Yes <input type="checkbox"/> ② No 4. During the past month, did you smoke? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: ___ # cigarettes per day <input type="checkbox"/> ④ Quit 5. During the past month, did you drink alcohol? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: ___ # glasses per day <input type="checkbox"/> ④ Quit (Note for ③: please say how many glasses, 'one glass' means: beer 330 ml, wine 120 ml, liquor 45 ml) 6. During the past month, did you chew betel quid? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day, ___ # quids per day <input type="checkbox"/> ④ Quit	7. Do you feel worried or depressed? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 8. Do you regularly feel chest discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 9. Do you regularly feel stomach discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 10. Do you regularly have headaches? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 11. Menstrual history ( <i>women only</i> ): (1) Your age at first menstruation: <input type="checkbox"/> ① Haven't begun menstruation yet <input type="checkbox"/> ② Age at first period: (2) Length of menstrual cycle: <input type="checkbox"/> ① ≤ 20 days <input type="checkbox"/> ② 21-40 days <input type="checkbox"/> ③ ≥ 41 days <input type="checkbox"/> ④ irregular ( <i>differing in length by more than 7 days</i> ) (3) Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain 12. Bowel habits: During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once every day <input type="checkbox"/> ② Once in 2 days <input type="checkbox"/> ③ Once in 3 days <input type="checkbox"/> ④ Once in 4 or more days 13. Internet use: During the past seven days ( <i>not including weekends, or days off</i> ), how many hours did you use the internet every day, apart from when doing homework or in class? <input type="checkbox"/> ① ≤ 1 hour <input type="checkbox"/> ② 1-2 (less than) hours <input type="checkbox"/> ③ 2-4 (less than) hours <input type="checkbox"/> ④ 4-5 (less than) hours <input type="checkbox"/> ⑤ ≥ 5 hours
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Self-rated Health	In general, during the past month, would you say your health is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor
	In general, during the past month, would you say your mental health is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor
	※ Do you currently have any health concerns? Please give details:

Health Examination Record (to be completed by medical personnel)										Date: Year ____ Month ____ Day								Examiner's Signature																																	
Height: ____ cm Weight: ____ kg										□Waistline: ____ cm																																									
Blood Pressure: ____ / ____ mmHg										Pulse rate: ____ /min																																									
Vision: Uncorrected: Left ____ Right ____										Corrected: Left ____ Right ____																																									
Eyes		□Normal			□Color blindness△ □Other:																																														
ENT		□Normal			Hearing abnormality: □Left □Right □Suspected otitis media ( <i>further diagnosis required</i> ), such as from a perforated ear drum □Swollen tonsils □Earwax embolism □Other:																																														
Head & Neck		□Normal			□Wry neck (torticollis) □Abnormal mass □Other:																																														
Chest		□Normal			□Cardiopulmonary disease □Abnormal thorax □Other:																																														
Abdomen		□Normal			□Abnormally swollen □Other:																																														
Spine & limbs		□Normal			□Scoliosis □Limb deformity □Difficulty squatting □Other:																																														
Genitourinary system		□Normal □Not checked			□Abnormal foreskin □Varicocele □Other:																																														
Skin		□Normal			□Ringworm □Scabies □Wart □Atopic dermatitis □Eczema □Other:																																														
Oral		□Normal			□Poor oral hygiene □Calculus □Gingivitis □Periodontitis □Dental malocclusion □Abnormal Oral Mucosa □Other:																																														
Dentition status: C-cavity; X-missing; △- filled;※ ϕ - impacted tooth;※ Sp.- supernumerary tooth※																																																			
Upper Right		<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr><td>18</td><td>17</td><td>16</td><td>15</td><td>14</td><td>13</td><td>12</td><td>11</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr> <tr><td>48</td><td>47</td><td>46</td><td>45</td><td>44</td><td>43</td><td>42</td><td>41</td><td>31</td><td>32</td><td>33</td><td>34</td><td>35</td><td>36</td><td>37</td><td>38</td></tr> </table>																18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Upper left	
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48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38																																				
Lower Right																		Lower Left																																	
Summary		<input type="checkbox"/> Normal <input type="checkbox"/> Requires a consultation with a: <input type="checkbox"/> Other:															Stamp of hospital/clinic where examination was done																																		
Laboratory Tests		1 <sup>st</sup> test	Result		Laboratory Tests		1 <sup>st</sup> test	Result																																											
			Abnormal	Follow up				Abnormal	Follow up																																										
Urinaly- sis		Protein (+) (-)			Blood lipid	Total cholesterol (mg/dl)																																													
		Sugar (+) (-)			Renal function	Creatinine (mg/dl)																																													
		O.B. (+) (-)				UA (mg/dl)																																													
		pH			Liver function	SGOT (U/L)																																													
Blood test		Hb (g/dl)				Hepatitis B	HBsAg																																												
		WBC (10 <sup>3</sup> /μL)			SGPT (U/L)																																														
		RBC (10 <sup>6</sup> /μL)				Anit-HBs																																													
		Platelet count (10 <sup>3</sup> /μL)				Other※																																													
		MCV (fl)																																																	
		Hct (%)																																																	
Chest X-ray		Date of X-ray	Result: <input type="checkbox"/> No obvious abnormality <input type="checkbox"/> R/O TB <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Other:															Further treatment, date, and comment:																																	
Other tests		Item	Date	Checked by	Result	Referred for follow-up, comment:																																													
Summary		Summary of health examination results, for follow-up or treatment, and case management outline																																																	