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| **National Ilan University**  **Student Health Examination Form Ministry of Education, Taiwan, R.O.C.** | | | | | | | | | | Student No. | | |  | | | | | | | |
| Basic  Information | Date of Entry | (mm)/(yy)  / | | Dept./Institute/Program | |  | | | | Name | | |  | | | | | | | |
| Date of Birth | (dd)/(mm)/(yy)  / / | | Blood Type |  | Gender | □M □F | | I.D. No. |  |  |  | |  |  |  |  |  |  |  |
| Permanent  address |  | | | | | | | | | | Cell phone | | | | | | | | |
| Mail  address | □As above | | | | | | | | | |  | | | | | | | | |
| Emergency contact | Relationship | Name | | | Phone (home) | | Phone (work) | | | | Student’s E-mail | | | | | | | | |
|  |  | | |  | |  | | | |  | | | | | | | | |
|  |  | | |  | |  | | | |
| Health  Information | Please tick of the ailments you have had (please add details for 13. to 18.):  □1. None □6. Kidney disease □11. Arthritis 　□16. Major surgery: \_\_\_\_  □2. Tuberculosis □7. Epilepsy 　 □12. Diabetes mellitus □17. Allergy:\_\_\_\_\_\_\_  □3. Heart disease □8. SLE (Lupus) □13.Psychological or mental illness:\_\_\_\_\_\_ □18.Other:  □4. Hepatitis □9. Hemophilia □14. Cancer:  □5. Asthma □10.G6PD deficiency □15. Thalassemia: | | | | | | | | | | | | | | | | | | | |
| High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye?  □0. No□1. Yes □2.Unknown | | | | | | | | | | | | | | | | | | | |
| Holder of Catastrophic Illness (including Rare Disease) Certificate: □0. No □1. Yes - Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Holder of Physical/Mental Disability Manual □0. No □1. Yes Category: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Level: □1.Mild □2. Moderate □3. Severe □4 Profound | | | | | | | | | | | | | | | | | | | |
| Special disease status or matters needing attention: □0. No □1. Yes (please describe): 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’ reference. | | | | | | | | | | | | | | | | | | | |
| Family medical/disease history:  Relative with hereditary disorder: □0. No □1. Yes Name of disease □2.Unknown  Relatives of family members suffering from major hereditary disorder: \_\_\_\_\_\_\_\_\_ Name of disease: \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |
| Regular Lifestyle | Tick the boxes that best describe your lifestyle:  1. How much did you sleep during the past 7 days (not including weekends, or days off)?  □≧7 hours a day □<7 hours a day□I suffer from insomnia  2. How many days did you eat breakfast during the past 7 days (not including weekends, or days off)?   □Never □Some days: days. □Every day (Eat: before 9:00 □Yes □No; after 9:00 □Yes □No )  3. During the past 7 days, how many days did you do moderate- intensity exercise, such as sports, fitness,transportation, and  recreational physical activities for at least 10 minutes each time per day?  □0 days □1 day □2 days □3 days □4 days □5 days □6 days □7 days  4. During the past month, did you use tobacco (including,cigarettes, e-cigarettes, and iQOS)?  □Not at all □Quit □Some days(□ⓐcigarettes □ⓑ e-cigarettes □ⓒ iQOS)□Every day ( □ⓐcigarettes   □ⓑe-cigarettes □ⓒiQOS ) □ Quit  5. During the past month, did you drink alcohol? □Not at all □Some days□Every day ( □ⓐ2 drinks or more□ⓑ1   drink □ⓒless than 1 drink )□Quit  (Note:please tick how many drinks,’standard drink’means : 330 ml,wine 120 ml ,liquor 45 ml)  6. During the past month, did you chew betel quid? □Not at all □Some days □Every day □Quit  7. Do you feel depressed? □Not at all □Sometimes □Often  8. Do you feel worried? □Not at all □Sometimes □Often  9. During the past 7 days, how often did you defecate?   □At least once every day □Once in 2 days □Once in 3 days □Once in 4 or more days  10. During the past 7 days (not including weekends, or days off), how many hours did you use the internet everyday, apart  from when doing homework or in class? □less than 2 hours □2-4 hours □4 hours or more: hours  11. How many times do you usually brush your teeth a day? □None □1 time □2 times □3 or more times  12. How often do you have a dental checkup even if there’s no toothache or other oral discomfort?   □Once every 6 months □Once a year □More than one year □Never  13. Menstrual history(women only): Do you have painful menstrual periods?   □No □Light pain □Severe pain □Unknown/Refused | | | | | | | | | | | | | | | | | | | |
| Health  Self | During the past month, would you say your health condition is □Excellent □Good □Average □Fair □Poor   1. During the past month, would you say your mental health condition is □Excellent □Good □Average □Fair □Poor | | | | | | | | | | | | | | | | | | | |
| ※Do you currently have any health concerns? □0. No □1. Yes：  ※Do you need the university/college to provide any assistance? □0. No □1. Yes | | | | | | | | | | | | | | | | | | | |

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| Health Examination Record  (to be completed by medical personnel) | | | | | | | | Date: Day Month Year | | | | | | | Examiner’s Signature | |
| Height: cm Weight: kg | | | | | | | | | □Waistline: cm BMI : | | | | | |  | |
| Blood Pressure: / mmHg Pulse rate: /min | | | | | | | | | | | | | | |  | |
| Vision: Uncorrected: Right Left Corrected: Right Left | | | | | | | | | | | | | | |  | |
| Eyes | | □Normal | | □Color vision deficiency □Other: | | | | | | | | | | |  | |
| ENT | | □Normal | | Hearing abnormality: □Left □Right  □Suspected otitis media, 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 | | □Abnormal swelling □Other: | | | | | | | | | | |
| Spine &  limbs | | □Normal | | □Scoliosis □Limb deformity □Difficulty squatting □Other: | | | | | | | | | | |
| Skin | | □Normal | | □Ringworm □Scabies □Wart □Atopic dermatitis □Eczema □Other: | | | | | | | | | | |
| Oral Health Screening | | □Normal | | Untreated caries: □0.No □1.Yes  Missing tooth (been extracted due to caries): □0.No □1.Yes  Filled tooth : □0. No □1. Yes  Gingivitis: □0. No □1. Yes  Dental calculus or tartar: □0.No □1.Yes  □Poor oral hygiene □Malocclusion □Other | | | | | | | | | | |  | |
| Summary | □Normal  □Requires a consultation with :  □Other: | | | | | | | | | | | Stamp of hospital/clinic where examination was done | | | | |
| Laboratory Tests | | | | | 1st  test | | Result | | | Laboratory Tests | | 1st  test | | Result | | |
| Abnormal | Follow up | | Abnormal | | Follow up |
| Urinalysis | Protein (＋) (－) | | | |  | |  |  | | Blood  lipid | Total cholesterol (mg/dl) |  | |  | |  |
| Sugar (＋) (－) | | | |  | |  |  | | HDL- cholesterol (mg/dl) |  | |  | |  |
| O.B. (＋) (－) | | | |  | |  |  | | Triglyceride(mg/dl) |  | |  | |  |
| pH | | | |  | |  |  | | Renal  function | Creatinine (mg/dl) |  | |  | |  |
| Blood  test | Hb (g/dl) | | | |  | |  |  | | UA (mg/dl) |  | |  | |  |
| WBC (103/μL) | | | |  | |  |  | | BUN (mg/dl) |  | |  | |  |
| RBC (106/μL) | | | |  | |  |  | | Liver  function | SGOT (U/L) |  | |  | |  |
| Platelet count (103/μL) | | | |  | |  |  | | SGPT (U/L) |  | |  | |  |
| MCV (fl） | | | |  | |  |  | | Hepatitis B | HBsAg |  | |  | |  |
| Hct (%) | | | |  | |  |  | | Anit-HBs |  | |  | |  |
|  | | | |  | |  |  | | Other | Fasting plasma |  | |  | |  |
| Chest  X-ray | Date of X-ray | | Result:  □No obvious abnormality □R/O TB □TB-related Calcification □Abnormal thorax □Pleural cavity edema □Scoliosis □Cardiomegaly □Bronchiectasis □Pulmonary infiltrates □Solitory pulmonary nodule □Other: | | | | | | | | | Further treatment, date, and comment: | | | | |
| Other  tests | Item | | | | | Date | | Checked by | | | Result | | Referred for follow-up, comment: | | | |
|  | | | | |  | |  | | |  | |  | | | |
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| Summary | Summary of health examination results, for follow-up or treatment, and case management outline | | | | | | | | | | | | | | | |