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| **Wenzao Ursuline University of Languages 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 | | □M □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. | | | | | | |
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| Health  Information | Medical History  Please tick any of the following ailments you have had (*please add details for 13. to 18*.): | | | | | | | | | | | | | Details of particular item/s or other matters requiring attention  □Details given in the attached file. | | | | | | | | | | | | | |
| □1. None  □2. Tuberculosis  □3. Heart disease  □4. Hepatitis  □5. Asthma  □6. Kidney disease | | □7. Epilepsy  □8. SLE (Lupus)  □9. Hemophilia  □10. G6PD deficiency  □11. Arthritis  □12. Diabetes mellitus | | | | □13. Psychological or mental illness:  □14. Cancer:  □15. Thalassemia:  □16. Major surgery:  □17. Allergy to: *………….*  □18. Other: | | | | | | |
| □Holder of Catastrophic Illness Certificate - Category:  □Holder of Physical/Mental Disability Manual - Category:  Level: □Very serious □Serious □Moderate □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 (*not including weekends, or days off*) ?: □➀≧7 hours a day □➁<7 hours a day □➂ I suffer from insomnia 2. How many days did you eat breakfast during the past 7 days (*not including weekends, or days off*)?: □➀Never   □➁Seldom: days □➂Every day at (time)?   1. During the past month (*not including weekends, days off, or winter or summer vacation*), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: □➀Yes □➁No 2. During the past month, did you smoke?: □➀No □➁Often □➂Every day:\_\_\_\_ # cigarettes per day □④Quit 3. During the past month, did you drink alcohol? □➀No   □➁Often □➂Every day: \_\_\_\_ # glasses per day  □④Quit (*Note for* ➂: *please say how many glasses,* ‘*one glass’ means: beer 330 ml, wine 120 ml, liquor 45 ml*)   1. During the past month, did you chew betel quid? □➀No □➁Often □➂Every day, \_\_\_\_ # quids per day □④Quit | | | | | | | | | 1. Do you feel worried or depressed？ □➀No □➁Seldom □➂Often 2. Do you regularly feel chest discomfort?  □➀No □➁Seldom □➂Often 3. Do you regularly feel stomach discomfort? □➀No □➁Seldom □➂Often 4. Do you regularly have headaches?  □➀No □➁Seldom □➂Often 5. Menstrual history (*women only*): 6. Your age at first menstruation: □➀Haven’t begun menstruation yet □➁Age at first period: 7. Length of menstrual cycle: □➀≦20 days □➁21-40 days □➂≧41 days □④irregular (*differing in length by more than 7*   *days*)   1. Do you have painful menstrual periods? □➀No  □➁ Light pain □➂ Severe pain 2. Bowel habits: During the past 7 days, how often did you defecate? □➀At least once every day □➁Once in 2 days □➂Once in 3 days □④Once in 4 or more days 3. Internet use: During the past seven days (*not including weekends, or days off*), how many hours did you use the internet every day, apart from when doing homework or in class? □➀≦1 hour □➁1-2 (less than)hours   □➂2-4 (less than) hours □④4-5 (less than) hours □⑤≧5 hours | | | | | | | | | | | | | | | | | |
| Self –rated Health | 1. In general, during the past month, would you say your health is □➀Excellent □➁Very good □➂Good □④Fair   □⑤Poor   1. In general, during the past month, would you say your mental health is □➀Excellent □➁Very good □➂Good □④Fair   □⑤Poor | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * Do you currently have any health concerns? Please give details: | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Health Examination Record  (to be completed by medical personnel) | | | | | | | | | | | | | | | Date: Year Month Day | | | | | | | | | | | | | | | | | Examiner’s Signature | |
| Height: cm Weight: kg | | | | | | | | | | | | | | | | | | *Optional* □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 (*further diagnosis required*), 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 □Bowlegged (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; ψ- impacted tooth; Sp.- supernumerary tooth  C-decayed; X-missing; 🛆- filled; ψ- impacted tooth; Sp.- Supernumerary tooth | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | |
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| Upper Right | | | 18 | | 17 | 16 | | 15 | | | 14 | | 13 | 12 | | 11 | 21 | | 22 | | 23 | 24 | | 25 | 26 | 27 | 28 | Upper left | | | |
| Lower Right | | | 48 | | 47 | 46 | | 45 | | | 44 | | 43 | 42 | | 41 | 31 | | 32 | | 33 | 34 | | 35 | 36 | 37 | 38 | Lower Left | | | |
|  | | |  | |  |  | |  | | |  | |  |  | |  |  | |  | |  |  | |  |  |  |  |  | | | |
| Summary | □Normal  □Requires a consultation with a:  □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 (＋) (－) | | | | | | | |  | | |  | | |  | | | | | Renal  function | | | Creatinine (mg/dl) | | | | | | |  |  | |  |
| O.B. (＋) (－) | | | | | | | |  | | |  | | |  | | | | | UA (mg/dl) | | | | | | |  |  | |  |
| pH | | | | | | | |  | | |  | | |  | | | | | BUN (mg/dl) ※ | | | | | | |  |  | |  |
| Blood  test | Hb (g/dl) | | | | | | | |  | | |  | | |  | | | | | Liver  function | | | SGOT (U/L) | | | | | | |  |  | |  |
| WBC (103/μL) | | | | | | | |  | | |  | | |  | | | | | SGPT (U/L) | | | | | | |  |  | |  |
| RBC (106/μL) | | | | | | | |  | | |  | | |  | | | | | Hepatitis B | | | HbsAg | | | | | | |  |  | |  |
| Platelet count (103/μL) | | | | | | | |  | | |  | | |  | | | | | HbsAb | | | | | | |  |  | |  |
| MCV (fl) | | | | | | | |  | | |  | | |  | | | | | Other | | |  | | | | | | |  |  | |  |
| Hct (%)※ | | | | | | | |  | | |  | | |  | | | | |  | | |  | | | | | | |  |  | |  |
| Chest  X-ray | Date of X-ray | | | Result:  □No obvious abnormality □R/O TB □TB-related Calcification □Abnormal thorax □Pleura cavity edema □Scoliosis □Cardiomegaly □Bronchiectasis □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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |