National Dong Hwa University Student Health Examination Form

Date: / / /

Contact Information

Student No		Dept./Institute/Class			Name		
Date of Birth	(yy)/(mm)/(dd) / /	Blood Type		Sex	□M □F	Passport 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

Please tick any of the following ailments you have had (*please add details for 13. to 18.*)

□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:_____

Details of particular item/s or other matters requiring attention

□Details given in the attached file.

High myopia: Is the myopia in either eye more than 5000 degrees currently? □0. No □ 1. Yes □ 2. Don't know

□Receive a certificate card for major injuries and illnesses (including rare diseases): □0. No □ 1. Yes

□Holder of Physical/Mental Disability Manual - Category□0. No □ 1. Yes

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□0. No □ 1. Yes ，Name of disease，□2.Don't know

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) ? □①≧7 hours a day □②□<7 hours a day③I suffer from insomnia
2. . How many days did you eat breakfast during the past 7 days (not including weekends, or days off) ? □⓪Never □①Some days: days □②Every day at (Eat before 9:00□Yes □No)
3. During the 7 days,how many days did you do moderateintensity exercise, such as sports, fitness, transportation,and recreational physical activities for at least 10minutes each time per day ? □⓪0 days □①1day □②2day □③3day □④4day □⑤5day □⑥6ay □⑦7day
4. During the past month, did you use tobacco(including cigarettes,e-cigarettes and iQOS) ? □①Not at all □②Quit □③Some days (□ⓐa cigarette□ⓑe-cigarettes□ⓒiQOS) □④Every day (□a cigarette□ⓑ e-cigarettes□ⓒiQOS)
5. During the past month, did you drink alcohol ? □①Not at all □②Some days □③Every day(□2 drinks or more □1 drink □less than 1 drink) □④Quit (Note: please tick how many drinks,standard drink means; beer 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 ? □①At least once every□ Once in 2 days □②Once in 3 days □③Once 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 every day,apart form when doing homework or in class ? □①less than 2 hours □②2-4 hours □③4 hours or more, hours
11. .How many times do you usually brush your teeth a day ?□①None □②1 time □③2 times 3 or more times
12. How often do you have a dental cheekup even if there no toothache or other oral discomfort ? □⓪Once every 6 months □②Once a year□③More then one year □④Never
13. .Menstual history (women only): Do you have painful menstral periods ? □①No □②Light pain □③Severe pain □④Unknown/Refused

Self –rated Health

1.In general, during the past month, would you say your health is □①Excellent □②Very good □③Good □④Fair□⑤Poor

2.In general, during the past month, would you say your mental health is □①Excellent □②Very good □③Good □④Fair □⑤Poor

※ Do you currently have any health concerns? Please give details:

1.The main pupose of the health examination is continue to care your health in University period,so please fill in the "basic health information" for the plan of health promotion.

2.For the right of personal privacy,do you agree Sannitary and health caring center sends your health examination results to the relevant department to assist and track.□agree / sign name: □disagree

3.Personal privacy protection statement:Based on the personal Data Protection Law,we will provide your health examination result as a reference for health policy assessment by the Minstry of Education.(Please download your health eximination results online if your age is over 20 years old.

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	Untreated caries:☐0. NO ☐1. Yes Missing tooth(been extracted due to caries):☐0.No ☐1.Yes Filled tooth (been filled due to caries, including crown ,inlay etc):☐0. No ☐1. Yes Gingivitis :☐0. No ☐1. Yes Dental calculus or tartar:☐0. No ☐1. Yes ☐Poor oral hygiene ☐Malocclusion ☐Others	

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 (+) (−)					TG(mg/dl)			
	O.B. (+) (−)					HDL(mg/dl)			
	pH					LDL(mg/dl)			
Blood test	Hb (g/dl)				Renal function	Creatinine (mg/dl)			
	WBC (10^3/μL)					UA (mg/dl)			
	RBC (10^6/μL)					BUN (mg/dl) ※			
	Platelet count (10^3/μL)				Liver function	SGOT (U/L)			
	MCV (fl)					SGPT (U/L)			
	Hct (%)※				Hepatitis B	HbsAg			
Other	AC suger					HbsAb			

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 ☐Pulmonary nodules ☐Other:_____	Further treatment, date, and comment:

Summary& suggestion	☐Nomal ☐Requires a consultation with a: ☐Others:	Stamp of hospital/clinc Where examination was done