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 □7. Epilepsy □13. Psychological or mental illness:_____
□2. Tuberculosis □8. SLE (Lupus) □14. Cancer:_____
□3. Heart disease □9. Hemophilia □15. Thalassemia:_____
□4. Hepatitis □10. G6PD deficiency □16. Major surgery:_____
□5. Asthma □11. Arthritis □17. Allergy to: ……._____
□6. Kidney disease □12. Diabetes mellitus □18. Other:_____

Details of particular item/s or other matters requiring attention
□Details given in the attached file.

High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye?
□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

Special Disease Status or Precautions:□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' 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 often did you eat breakfast in the past 7 days (not including weekends, or days off) ?
□⓪Never □①Some days: days □②Every 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/high intensity exercise(that is, you could talk but not sing while performing the exercise), such as sports, fitness,commuting, and recreational physical activities for at least 10 minutes each time per day? □⓪0 days □①1day □②2day □③3day □④4day □⑤5day □⑥6ay □⑦7day

4.During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? □①Not at all
□②Some days -please tick: □ⓐcigarettes□ⓑe-cigarettes □ⓒiQOS (multiple choice)
□③Every day - please tick: □ⓐcigarettes□ⓑe-cigarettes □ⓒiQOS (multiple choice) □④I have quit

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) □④ I have quit
(Note: 1 'drink' means: 330 ml of beer, 120 ml of wine, 45 ml of spirits)

6.During the past month, did you chew betel nut ? □Not at all □Some days □Every day □I have 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 □②Once in 2 days □③Once in 3 days □④Once 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 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 ? □⓪None □①Once □②Twice □③3 or more times

12.How often do you have a dental cheekup even if there no toothache or other oral discomfort ?
□①Once every 6 months □②Once a year□③More then one year □④Never

13.Menstrual cycle – female students: Do you have painful menstrual periods?
□①No □②Light pain □③Severe pain □④Unknown/Declined to answer

Self –rated Health

1.During the past month, would you say your health is □①Excellent □②Good □③Average □④Fair □⑤Poor

2.During the past month, would you say your mental health condition is□①Excellent□②Good□③Average□④Fair□⑤Poor

※ Do you currently have any health concerns? □0. No □1. Yes

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)

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 swelling ☐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		Stamp of hospital/clinic where examination was done
	☐Normal ☐Requires a consultation with :_____ ☐Other:_____	

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(AST) (U/L)			
	MCV (fl)					SGPT (ALT) ((U/L)			
	Hct (%)※				Hepatitis B	HbsAg			
Other	AC suger					Anti-HBs			

Chest X-ray	Date of X-ray	Result:	Further treatment, date, and comment:
		☐No obvious abnormality ☐R/O TB ☐TB-related Calcification ☐Abnormal thorax ☐Pleura cavity edema ☐Scoliosis ☐Cardiomegaly ☐Bronchiectasis ☐Pulmonary infiltrates ☐Solitayy pulmonary nodule ☐Other:_____	

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