National Pingtung University Student Health Examination Form

Student No.	

Basic 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.	
Mailing address	☐ As above:						

Emergency contact	Relationship	Name	Phone (home/cell)	Phone (work)	Student's Email

Health Information

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: 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 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 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 often did you eat breakfast in 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/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? ☐0 day ☐1 day ☐2 days ☐3 days ☐4 days ☐5 days ☐6 days ☐7 days
4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? ☐Not at all
   ☐Some days -please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice)
   ☐very day - please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice) ☐I have quit
5. During the past month, did you drink alcohol? ☐Not at all ☐Somedays
   ☐ Every day - please tick how many: ☐ⓐ2 drinks or more ☐ⓑ1 drink ☐ⓒless than 1 drink ☐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?
   ☐At least once a 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 ☐Once ☐Twice ☐3 or more times
12. How often do you have a dental checkup even if there's notoothache or other oral discomfort?
    ☐Once every 6 months ☐Once a year ☐More than one year ☐Never
13. Menstrual cycle – female students: Do you have painful menstrual periods?
    ☐No ☐Light pain ☐Severe pain ☐ Unknown/Declined to answer
14. During the past month, did you drink sugar drinks? ☐Not at all ☐Somedays ☐ Every day - please tick how many:____
    ☐I have quit

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:

Health Examination Record (to be completed by medical personnel)	Date: Year_____ Month_____ Day_____	Examiner's Signature
Height:_____cm Weight:_____kg	*Optional* ☐Waistline:_____cm BMI:_____	
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 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 tarta: □0.No □1.Yes □Poor oral hygiene □Malocclusion □Other:	

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 sugar	AC sugar (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 ($10^3/\mu L$)					SGPT (U/L)			
	RBC ($10^6/\mu L$)				Hepatitis B	HbsAg			
	Platelet count ($10^3/\mu L$)					HbsAb			
	MCV (fl)					HBeAg			
	Hct (%)※				Blood lipid	Total cholesterol (mg/dl)			
						Triglyceride			

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:

Summary	Summary of health examination results, for follow-up or treatment, and case management outline