

NCYU Student Health Examination Form

健康編號： _____

Food intake _____ Menstrual period Pregnant Suspected pregnancy 檢查日期： 年 月 日 報到時間： _____

Basic Information	Name		Dept./Institute/Class				Student No.				
	Date of Birth		Blood Type		Sex	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.				
	Permanent address						Cell phone No.				
	Mailing address		<input type="checkbox"/> As above								
	Emergency contact (Parents or guardian)		Relationship	Name	Phone (home)	Phone (work)	Student's E-mail				
Health Information	Medical History Please tick any of the following ailments you have had (please add details for 13. to 18) <input type="checkbox"/> 1. None <input type="checkbox"/> 6. Kidney disease <input type="checkbox"/> 11. Arthritis <input type="checkbox"/> 16. Major surgery : _____ <input type="checkbox"/> 2. Tuberculosis <input type="checkbox"/> 7. Epilepsy <input type="checkbox"/> 12. Diabetes mellitus <input type="checkbox"/> 17. Allergy to : _____ <input type="checkbox"/> 3. Heart disease <input type="checkbox"/> 8. SLE (Lupus) <input type="checkbox"/> 13. Psychological or mental illness : _____ <input type="checkbox"/> 18. Other : _____ <input type="checkbox"/> 4. Hepatitis <input type="checkbox"/> 9. Hemophilia <input type="checkbox"/> 14. Cancer : _____ <input type="checkbox"/> 5. Asthma <input type="checkbox"/> 10. G6PD deficiency <input type="checkbox"/> 15. Thalassemia : _____										
	High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. Unknown										
	Holder of Catastrophic Illness (including Rare Disease) Certificate : <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes – Category : _____ Holder of Physical/Mental Disability Manual <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Category : _____ Level: <input type="checkbox"/> 1. Mild <input type="checkbox"/> 2. Moderate <input type="checkbox"/> 3. Severe <input type="checkbox"/> 4 Profound										
	Special disease status or matters needing attention : <input type="checkbox"/> 0. No <input type="checkbox"/> 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 : <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Name of disease _____ <input type="checkbox"/> 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)? <input type="checkbox"/> ① ≥7 hours a day <input type="checkbox"/> ② <7 hours a day <input type="checkbox"/> ③ I suffer from insomnia										
	2. How often did you eat breakfast in the past 7 days (not including weekends, or days off)? <input type="checkbox"/> ① Never <input type="checkbox"/> ② Some days: ___ days. <input type="checkbox"/> ③ Every day (Eat: before 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> No; after 9 : 00 <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> ① 0 days <input type="checkbox"/> ② 1 day <input type="checkbox"/> ③ 2 days <input type="checkbox"/> ④ 3 days <input type="checkbox"/> ⑤ 4 days <input type="checkbox"/> ⑥ 5 days <input type="checkbox"/> ⑦ 6 days <input type="checkbox"/> ⑧ 7 days										
	4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or IQOS)? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days - please tick: <input type="checkbox"/> (a) cigarettes <input type="checkbox"/> (b) e-cigarettes <input type="checkbox"/> (c) IQOS (multiple choice) <input type="checkbox"/> ③ Every day - please tick: <input type="checkbox"/> (a) cigarettes <input type="checkbox"/> (b) e-cigarettes <input type="checkbox"/> (c) IQOS (multiple choice) <input type="checkbox"/> ④ I have quit										
	5. During the past month, did you drink alcohol? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day - please tick how many: <input type="checkbox"/> (a) 2 drinks or more <input type="checkbox"/> (b) 1 drink <input type="checkbox"/> (c) less than 1 drink <input type="checkbox"/> 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? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day <input type="checkbox"/> ④ I have quit										
	7. Do you feel depressed? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often										
	8. Do you feel worried? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often										
	9. During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once a day <input type="checkbox"/> ② Once in 2 days <input type="checkbox"/> ③ Once in 3 days <input type="checkbox"/> ④ 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? <input type="checkbox"/> ① less than 2 hours <input type="checkbox"/> ② 2-4 hours <input type="checkbox"/> ③ 4 hours or more: ___ hours										
	11. How many times do you usually brush your teeth a day? <input type="checkbox"/> ① None <input type="checkbox"/> ② Once <input type="checkbox"/> ③ Twice <input type="checkbox"/> ④ 3 or more times										
	12. How often do you have a dental checkup even if there's no toothache or other oral discomfort? <input type="checkbox"/> ① Once every 6 months <input type="checkbox"/> ② Once a year <input type="checkbox"/> ③ More than one year <input type="checkbox"/> ④ Never										
13. Menstrual cycle – female students: Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain <input type="checkbox"/> ④ Unknown/Declined to answer											
Health Self	1. During the past month, would you say your health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor										
	2. During the past month, would you say your mental health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor										
	※ Do you currently have any health concerns? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes ※ Do you need the university/college to provide any assistance? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes										

Health Examination Record (to be completed by medical personnel)		Date : Year _____ Month _____ Day _____			Examiner's Signature					
Height : _____ cm Weight : _____ kg Waistline : _____ cm										
Blood Pressure : _____ / _____ mmHg Pulse rate : _____ /min Recheck _____ / _____ mmHg Pulse rate : _____ /min										
Vision : Uncorrected : Right _____ Left _____ Corrected : Right _____ Left _____										
Color vision deficiency : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal										
Hearing abnormality : Right <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____ Left <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal: _____										
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Other : _____								
ENT	<input type="checkbox"/> Normal	<input type="checkbox"/> Suspected otitis media (<i>further diagnosis required</i>), such as from a perforated eardrum <input type="checkbox"/> Swollen tonsils <input type="checkbox"/> Earwax embolism <input type="checkbox"/> Other : _____								
Head & Neck	<input type="checkbox"/> Normal	<input type="checkbox"/> Wry neck (torticollis) <input type="checkbox"/> Abnormal mass <input type="checkbox"/> Other : _____								
Chest	<input type="checkbox"/> Normal	<input type="checkbox"/> Cardiopulmonary disease <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Other : _____								
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormally swollen <input type="checkbox"/> Other : _____								
Spine &limbs	<input type="checkbox"/> Normal	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Limb deformity <input type="checkbox"/> Bowlegged (Difficulty squatting) <input type="checkbox"/> Other : _____								
Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Ringworm <input type="checkbox"/> Scabies <input type="checkbox"/> Wart <input type="checkbox"/> Atopic dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Other : _____								
Oral Health Screening	<input type="checkbox"/> Normal	Untreated caries : <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes Missing tooth (been extracted due to caries) : <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes Filled tooth : <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Gingivitis : <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Dental calculus or tartar : <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Malocclusion <input type="checkbox"/> Other								
Chest X-ray	Date of X-ray	Result : <input type="checkbox"/> No obvious abnormality <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> R/O TB <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Other : _____ Because : <input type="checkbox"/> pregnancy <input type="checkbox"/> other _____ , I refuse this check. Signature : _____				Further treatment, date, and comment :				
Laboratory Tests		1 st test	Result		Laboratory Tests		1 st test	Result		
			Abnormal	Follow up				Abnormal	Follow up	
Urinalysis	U-PRO(+)(-)				Renal function	Creatinine (mg/dl)				
	U-GLU(+)(-)					BUN(mg/dl)				
	U-O.B. (+)(-)					UA (mg/dl)				
	U-PH				Blood lipid	Total cholesterol (mg/dl)				
Hb (g/dl)				TG (mg/dl)						
WBC (10 ³ /μL)				HDL-C(mg/dl)						
RBC (10 ⁶ /μL)				LDL-C(mg/dl)						
Blood test	Platelet count (10 ³ /μL)				Liver function	SGOT (U/L)				
	MCV (fl)					SGPT (U/L)				
	Hct (%)				Hepatitis B	HBsAg				
	MCH(pg)					Anti-HBs				
MCHC(g/dl)				other	AC Sugar (mg/dl)					
Summary	<input type="checkbox"/> Normal <input type="checkbox"/> Requires a consultation with a : _____ <input type="checkbox"/> Other : _____						Stamp of hospital/clinic where examination was done			
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									