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	☐M ☐F	I.D. No.	
Permanent address						Cell phone No.	
Mailing address	☐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

☐1. None ☐6. Kidney disease ☐11. Arthritis ☐16.Major surgery：_____
☐2. Tuberculosis ☐7. Epilepsy ☐12. Diabetes mellitus ☐17. Allergy to：_____
☐3. Heart disease ☐8. SLE (Lupus) ☐13. Psychological or mental illness：_____ ☐18. Other：_____
☐4. Hepatitis ☐9. Hemophilia ☐14. Cancer：_____
☐5. Asthma ☐10. G6PD deficiency ☐15. Thalassemia：_____

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 (including Rare Disease) Certificate：☐0. No ☐1. Yes – Category：_____
Holder of Physical/Mental Disability Manual ☐0. No ☐1. Yes Category：_____
Level: ☐1.Mild ☐2. Moderate ☐3. Severe ☐4 Profound

Special disease status or matters needing attention：☐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' reference.

Family medical/disease history：
Relative with hereditary disorder：☐0. No ☐1. Yes Name of disease_____ ☐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)?
   ☐①≥7 hours a day ☐②<7 hours a day ☐③I suffer from insomnia
2. How often did you eat breakfast in the past 7 days *(not including weekends, or days off*)?
   ☐①Never ☐②Some days:__days. ☐③Every 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?☐①0 days ☐②1 day ☐③2 days ☐④3 days ☐⑤4 days ☐⑥5 days ☐⑦6 days ☐⑧7 days
4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? ☐①Not at all
   ☐②Some days -please tick: ☐(a)cigarettes ☐(b)e-cigarettes ☐(c)iQOS (multiple choice)
   ☐③Every day - please tick: ☐(a)cigarettes ☐(b)e-cigarettes ☐(c)iQOS (multiple choice) ☐④I have quit
5. During the past month, did you drink alcohol? ☐①Not at all ☐②Some days
   ☐③Every day - please tick how many: ☐(a)2 drinks or more ☐(b)1 drink ☐(c)less than 1 drink ☐④I 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? ☐①Not at all ☐②Some days ☐③Every day ☐④I have quit
7. Do you feel depressed? ☐①Not at all ☐②Sometimes ☐③Often
8. Do you feel worried? ☐①Not at all ☐②Sometimes ☐③Often
9. During the past 7 days, how often did you defecate?
   ☐①At least once a day ☐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 from 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 ☐②Once ☐③Twice ☐④3 or more times
12. How often do you have a dental checkup even if there's no toothache or other oral discomfort?
    ☐①Once every 6 months ☐②Once a year ☐③More than one year ☐④Never
13. Menstrual cycle – *female students*: Do you have painful menstrual periods?
    ☐①No ☐②Light pain ☐③Severe pain ☐④Unknown/Declined to answer

Health Self

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

※Do you currently have any health concerns? ☐0. No ☐1. Yes
※Do you need the university/college to provide any assistance? ☐0. No ☐1. Yes

Health Examination Record (to be completed by medical personnel)	Date：Year_____ Month_____ Day_____	Examiner's Signature
Weight：_____kg	Height：_____cm	Waistline：_____cm
Blood Pressure：_____/_____mmHg	Pulse rate：_____/min	Recheck_____/_____mmHg Pulse rate：_____/min
Vision： Uncorrected：Right_____ Left_____	Corrected：Right_____ Left	
Color vision deficiency：☐Normal ☐Abnormal		
Hearing abnormality：Right ☐Normal ☐Abnormal:_____	Left ☐Normal ☐Abnormal:_____	

Eyes	☐Normal	☐Other：_____	
ENT	☐Normal	☐Suspected otitis media (*further diagnosis required*), such as from a perforated eardrum ☐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：_____	
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 tartar： ☐0.No ☐1.Yes ☐Poor oral hygiene ☐Malocclusion ☐Other	

Chest X-ray	Date of X-ray	Result：☐No obvious abnormality ☐TB-related Calcification ☐Abnormal thorax ☐Pleura cavity edema ☐Scoliosis ☐R/O TB □Cardiomegaly ☐Bronchiectasis ☐Other：_____ **Because**：☐**pregnancy** ☐**other**_____，**I refuse this check.** **Signature**：_____	Further treatment, date, and comment：

Laboratory Tests		1st test	Result		Laboratory Tests		1st 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 lipids	Total cholesterol (mg/dl)			
Blood test	Hb (g/dl)					TG (mg/dl)			
	WBC (10^3/μL)					HDL-C (mg/dl)			
	RBC (10^6/μL)					LDL-C (mg/dl)			
	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	☐Normal ☐Requires a consultation with a：_____ ☐Other：_____	Stamp of hospital/clinic where examination was done

	Item	Date	Checked by	Result	Referred for follow-up, comment：
Other tests					

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