Date of Finity       (Yy)(fmm) (Dept/finatiute/Class       Name         Date of Birth       (Yy)(fmm)(dd)       Blood Type       Sex       M       T       I.D. No.         Date of Birth       (Yy)(fmm)(dd)       Blood Type       Sex       M       T       I.D. No.         Permanent address       f/different from above:       Cell phone No.       Cell phone No.       Attach photo bare         Please check ( ✓ ) :       1.       Do you authorize FJCU to use your medical results for purposes of academic research? All of your personal information will be kept strictly confidential, only your medical results will be collected.       Yes (please sign):       No         No       2.       FJCU wants to improve medical services for new students and provide medical treatment in a comprehensive and timely manner for students whose medical exam reveals an abnormality. If your medical exam reveals an abnormal result, do you authorize FJCU to forward this information as well as your contact details to the Fu Jen Clinic for follow-up treatment?         Yes (please sign):		ol Name <u></u> nistry of E	Education,	_Student Hea Taiwan, R.				rsion)	Student No.								
Use of Brit       W' / / Type       Sex       Def       Def       D. No.         Permanent address       Cell phone No.       Cell phone No.       Attach photo bere         Particular       Cell phone No.       Attach photo bere         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Relationship       Name       Phone (home)       Phone (work)       Cell phone No.         Permanent address       Set Structure       Image: Set Structure       Image: Set Structure       Image: Set Structure       Attach photo bere         Press       No       Set Structure       Set Structure       Set Structure       Photo: Set Structure       Attach photo         Information will be kept strictly confidential, only our mecic		Date of Entry	(yy)/(mm)	Dept./Institute	/Class				Name								
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Primegory [Carents or guardian]       Name       Prime (Nonk)       Cent prime (Nonk)       Cent prime (Nonk)       Primegory [Carents or guardian]         Please check (✓):       1.       Do you authorize FJCU to use your medical results for purposes of academic research? All of your personal information will be kept strictly confidential, only your medical results will be collected.	ntact mation	Permanent address Mailing				1			Cell phone	e No.	- Attach photo						
Primegory [Carents or guardian]       Name       Prime (Nonk)       Cent prime (Nonk)       Cent prime (Nonk)       Primegory [Carents or guardian]         Please check (✓):       1.       Do you authorize FJCU to use your medical results for purposes of academic research? All of your personal information will be kept strictly confidential, only your medical results will be collected.	nfor	address		ibove:													
(Parents or guardian)		Emergency	Relationship	Name	Phon	e (home)	Phone	(work)	Cell phone	e No.	here						
1. Do you authorize FJCU to use your medical results for purposes of academic research? All of your personal information will be kept strictly confidential, only your medical results will be collected.            Yes (please sign):           No          2. FJCU wants to improve medical services for new students and provide medical treatment in a comprehensive and timely manner for students whose medical exam reveals an abnormality. If your medical exam reveals an abnormal result, do you authorize FJCU to forward this information as well as your contact details to the Fu Jen Clinic for follow-up treatment?            Yes (please sign):           No             No           Do you smoke?             Yes (please sign):           No             No           Do you smoke?             Yes (clease sign):           No             No           Do you smoke?             Yes           Cigarettes per day. (CO blood level:             No           No             S. Have you completed the online Lifestyle Questionnaire? (If not, please complete the copy on the following page.)             Yes           No             No           Details of particular item/s or other matters requiring attention             Datelist of particular item/s or other matters equiring at	-	(Parents or									-						
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□       Yes (please sign):         □       No         2. FJCU wants to improve medical services for new students and provide medical treatment in a comprehensive and timely manner for students whose medical exam reveals an abnormal result, do you authorize FJCU to forward this information as well as your contact details to the Fu Jen Clinic for follow-up treatment?         □       Yes (please sign):         □       No         3. Do you smoke?       ``         □       Yes:         □       igarettes per day. (CO blood level:         □       No         4. Have you completed the online Lifestyle Questionnaire? (If not, please complete the copy on the following page.)         □       Yes         □       No         5. Have you completed the online Mental Health Survey? (If not, please complete the copy on the following page.)         □       Yes         □       No         Medical History       Please tick any of the following ailments you have had (please add details for 13. to 18.):       matters requiring attention         □       No       □       Details of particular item/s or other         □       No       □       Details of particular item/s or other         □       □       No       □       Details given in the attached file.         □       □       No <t< td=""><td></td><td>-</td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>		-		-							•						
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abnormal result, do you authorize FJCU to forward this information as well as your contact details to the Fu Jen Clinic for follow-up treatment?         Yes (please sign):         No         3. Do you smoke?         Yes:       cigarettes per day. (CO blood level:         No         4. Have you completed the online Lifestyle Questionnaire? (If not, please complete the copy on the following page.)         Yes         No         5. Have you completed the online Mental Health Survey? (If not, please complete the copy on the following page.)         Yes         No         6. No         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:         Details of particular item/s or other matters requiring attention         1. None       16. Kidney disease         3. Heart disease       9. Hemophilia         15. Thalassemia:       Details given in the attached file.         16. Kidney disease       12. Diabetes mellitus       18. Other:         14. Hepatitis       10. GoPD deficiency       16. Major surgery:         14. Holder of Catastrophic Illness Certificate - Category:			-				-				-						
Clinic for follow-up treatment?  Yes (please sign):  No Do you smoke?  Yes:		-						-	-								
□ Yes (please sign):			-		o Iorwar	a this ir	formation a	as well as	your conta	ct deta	ills to the Fu Jer						
□ No         3. Do you smoke?         □ Yes: cigarettes per day. (CO blood level:)         □ No         4. Have you completed the online Lifestyle Questionnaire? (If not, please complete the copy on the following page.)         □ Yes         □ No         5. Have you completed the online Mental Health Survey? (If not, please complete the copy on the following page.)         □ Yes         □ No         Medical History         Please tick any of the following ailments you have had ( <i>please add details for 13. to 18.</i> ):         □ 1. None       □7. Epilepsy         □ 3. Heard disease       □9. Hemophilia         □ 5. Asthma       □10. GGPD deficiency         □ 6. Kidney disease       12. Diabetes mellitus         □ Holder of Physical/Mental Disability Manual - Category:																	
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Yes         No         Medical History         Please tick any of the following ailments you have had ( <i>please add details for 13. to 18.</i> ):         1. None       7. Epilepsy         13. Psychological or mental illness:         2. Tuberculosis       8. SLE (Lupus)         14. Cancer:       Details given in the attached file.         3. Heart disease       9. Hemophilia       15. Thalassemia:         3. Heart disease       10. G6PD deficiency       16. Major surgery:         5. Asthma       11. Arthritis       17. Allergy to:         6. Kidney disease       12. Diabetes mellitus       18. Other:         Holder of Physical/Mental Disability Manual - Category:       Level:         Holder of Physical/Mental Disability Manual - Category:       Level:         If you are being treated for or recovering from any of the above or some other disease, please inform the medical personnel and		🗌 No															
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If you are being treated for or recovering from any of the above or some other disease, please inform the medical personnel and																	
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Family medical history: relative with hereditary disease Name of disease					-			Name of di	sease								

	<ul><li>Tick the box that best describes your lifestyle:</li></ul>	7. Do you feel worried or depressed ?									
	1. How much did you sleep during the past 7 days <u>(not including</u> )										
	weekends, or days off)?:	8. Do you regularly feel chest discomfort?									
	$\square \bigcirc \ge 7$ hours a day $\square \oslash < 7$ hours a day	□ <sup>①</sup> No □ <sup>②</sup> Seldom □ <sup>③</sup> Often									
	□③ I suffer from insomnia	9. Do you regularly feel stomach discomfort?									
	2. How many days did you eat breakfast during the past 7 days	□ ①No □ ②Seldom □ ③Often									
	(not including weekends, or days off)?:	10.Do you regularly have headaches?									
	□ <sup>①</sup> Never	□ <sup>①</sup> No □ <sup>②</sup> Seldom □ <sup>③</sup> Often									
	OSeldom:days      GEvery day at (time)?	11.Menstrual history (women only):									
	3. During the past month (not including weekends, days off. or	(1) Your age at first menstruation:									
	winter or summer vacation), have you exercised three times a	①①Haven't begun menstruation yet									
	week, for at least 30 minutes each time, and achieving a	@Age at first period:									
	heartbeat rate of 130 bpm each time $\underline{?}$ : $\Box$ $\bigcirc$ Yes $\Box$ $\bigcirc$ No	(2) Length of menstrual cycle:									
•	4. During the past month, did you smoke?:	$\square$ $\bigcirc$ $\le$ 20 days $\square$ $\bigcirc$ 21-40 days $\square$ $\bigcirc$ $\ge$ 41 days									
tyle	□ <sup>①</sup> No □ <sup>②</sup> Often	$\Box$ $\textcircled{ Irregular } (differing in length by more than 7$									
Lifestyle	③Every day:       #( cigarettes e- cigarettes iQOS)	days)									
Ĺ	☐⊕Quit	(3) Do you have painful menstrual periods?									
	5. During the past month, did you drink alcohol?	□ <sup>①</sup> No □ <sup>②</sup> Light pain									
	□ <sup>①</sup> No □ <sup>②</sup> Often □ <sup>③</sup> Every day: # glasses per day	□③ Severe pain □④unknown/refused									
	⊡⊕Quit	12.Bowel habits: During the past 7 days, how often did you									
	(Note for ③: please say how many glasses, 'one glass' means:	defecate?									
6	beer 330 ml, wine 120 ml, liquor 45 ml)	$\Box$ ①At least once every day $\Box$ ②Once in 2 days									
	6. During the past month, did you chew betel quid?	□③Once in 3 days □④Once in 4 or more days									
	□ ONo □ Often □ 3Every day, # quids per day	13.Internet use: During the past seven days ( <i>not including</i>									
	⊡⊕Quit	weekends, or days off), how many hours did you use the									
		internet every day, apart from when doing homework or									
		in class?									
		$\square \oplus \leq 1$ hour $\square @1-2$ (less than)hours									
		$\square$ 32-4 (less than) hours $\square$ 4-5 (less than) hours									
		$\Box$ $\bigcirc \geq 5$ hours									
th	1. In general, during the past month, would you say your health is	3									
Ieal	DExcellent OVery good OGGood OFFair OSPoor										
t be	2. In general, during the past month, would you say your mental health is										
Selfrated Health	DExcellent @Very good @Good @Fair @SPoor										
Self	* 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															
Blood Pressure: / mmHg Pulse rate: /min																						
Vision: Uncorrected: LeftRight Corrected: Left Right high myopia																						
Eyes Normal Color blindness Other:																						
				]	Heari	ng ał	onorm	ality:		eft	Rig	ght										
ENT		Normal		Suspected otitis media ( <i>further diagnosis required</i> ), such as from a perforated ear drum Swollen tonsils Earwax embolism Other:																		
Head & Ne	ck [	Nori	nal	[	Wr	y nec	ck (tor	ticoll	lis)	Ab	norm	al ma	ss [	Oth	er:		_					
Chest	-	_ ]Nori		[	Wry neck (torticollis)       Abnormal mass       Other:         Cardiopulmonary disease       Abnormal thorax       Other:																	
Abdomer	1 [	Nor	nal	[	Abnormally swollen Other:																	
Spine & limbs		Nori	nal	[		oliosi	is 🗌	]Limł	o defe													
Genitourina		]Nori		, [	Ab	norm	nal for	eskin	L .	Varico	ocele		Other	:								
system Skin		]Not ]Nori		ted				Seck		Wat	+ □	Atoni	a dar	matiti		Forton		Oth				
SKIII			nai	l		-													er:			
Oral		Nori	nal	[			al hyg maloc			]Calc ]Abn			-	ivitis xosa		Period Other:						
Dentition st	atus:	C-cav	ity;	X-mi	ssing	;; Z	۵- fill	ed;	ψ- in	pacte	d too	oth;	Sp s	superr								
Upper Rig	rht	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Uı	ner left			
Lower Rig	-				45	44	-	42	41	31												
Summary	Re						a:													Stamp of hospital/clinic where examination was done		
					1	st		Res	sult										1 <sup>st</sup>	I	Result	
La	borate	ratory Tests			te		Abnor	mal	Folle	ow up				Laboratory Tests					test	Abnorm	al Follow up	
	Protein $(+)(-)$										Blood lipid	To	Total cholesterol (mg/dl)									
Urinalysis	$\operatorname{Sugar}(+)(-)$									р	Renal	Cro	Creatinine (mg/dl)									
	O.B. (+) (-)											UA	UA (mg/dl)									
	pН									- 1u	nctior	BU	BUN (mg/dl) 💥									
	Hb (g/dl)									Ι	Liver	SG	SGOT (U/L)									
	WBC (10 <sup>3</sup> /µL)									fu	nctior	I SG	PT (U	J/L)								
Blood	RBC (10 <sup>6</sup> /µL)							Hepat			patiti	, Hb	HbsAg									
test	Platelet count $(10^3/\mu L)$			)							В	Hb	sAb									
	MCV (fl)									0	Other											
	Hct (%) 🔆																					
								$\square$ P	]R/O TB ]Pleura cavity edema ]Bronchiectasis					☐TB-related Calcification ☐Scoliosis ☐Other:					Further treatment, date, and comment:			
Other		Item			Date			Checked by				Result					Referred for follow-up, comment:					
Summary	Sumr	nary o	of hea	lth ex	amin	ation	n resul	ts, fo	r folle	ow-up	or tr	eatme	ent, a	nd cas	se ma	nagei	nent	outli	ne			