School Name_____Student Health Examination Form

Ministry of Education, Taiwan, R.O.C. (Revised Version)

Student No.	

Contact 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.	Attach photo here		
Mailing address	*If different from above*:								
Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.				

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
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
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

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.

☐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 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 day
   ☐③ I suffer from insomnia
2. How many days did you eat breakfast during the past 7 days (*not including weekends, or days off*)?:
   ☐①Never
   ☐②Seldom:____days ☐③Every day at (time)?_____
3. During the past month (*not including weekends, days off, or winter or summer vacation*), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: ☐①Yes ☐②No
4. During the past month, did you smoke?:
   ☐①No ☐②Often
   ☐③Every day:____ #(☐cigarettes ☐e- cigarettes☐iQOS)
   ☐④Quit
5. During the past month, did you drink alcohol?
   ☐①No ☐②Often ☐③Every day: ____ # glasses per day
   ☐④Quit
   (*Note for ③: please say how many glasses, 'one glass' means: beer 330 ml, wine 120 ml, liquor 45 ml*)
6. During the past month, did you chew betel quid?
   ☐①No ☐②Often ☐③Every day, ____ # quids per day
   ☐④Quit
7. Do you feel worried or depressed ?
   ☐①No ☐②Seldom ☐③Often
8. Do you regularly feel chest discomfort?
   ☐①No ☐②Seldom ☐③Often
9. Do you regularly feel stomach discomfort?
   ☐①No ☐②Seldom ☐③Often
10. Do you regularly have headaches?
    ☐①No ☐②Seldom ☐③Often
11. Menstrual history (*women only*):
    (1) Your age at first menstruation:
    ☐①Haven't begun menstruation yet
    ☐②Age at first period:_____
    (2) Length of menstrual cycle:
    ☐①≦20 days ☐②21-40 days ☐③≧41 days
    ☐④irregular (*differing in length by more than 7 days*)
    (3) Do you have painful menstrual periods?
    ☐①No ☐② Light pain
    ☐③ Severe pain ☐④unknown/refused
12. Bowel habits: During the past 7 days, how often did you defecate?
    ☐①At least once every day ☐②Once in 2 days
    ☐③Once in 3 days ☐④Once in 4 or more days
13. Internet use: During the past seven days (*not including weekends, or days off*), how many hours did you use the internet every day, apart from when doing homework or in class?
    ☐①≦1 hour ☐②1-2 (less than)hours
    ☐③2-4 (less than) hours ☐④4-5 (less than) hours
    ☐⑤≧5 hours

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	
Blood Pressure:_____/_____mmHg Pulse rate:_____/min		
Vision: Uncorrected: Left_____Right_____ Corrected: Left_____ Right_____ ☐ high myopia		

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 ☐Difficulty squatting ☐Other:_____
Genitourinary system	☐Normal ☐Not checked	☐Abnormal foreskin ☐Varicocele ☐Other:_____
Skin	☐Normal	☐Ringworm ☐Scabies ☐Wart ☐Atopic dermatitis ☐Eczema ☐Other:_____
Oral	☐Normal	☐Poor oral hygiene ☐Calculus ☐Gingivitis ☐Periodontitis ☐Dental malocclusion ☐Abnormal Oral Mucosa ☐Other:_____

Dentition status: C-cavity; X-missing; △- filled; ψ- impacted tooth; Sp.- supernumerary tooth

Upper Right	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper left
Lower Right	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower Left

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

Laboratory Tests		1st test	Result: Abnormal	Result: Follow up	Laboratory Tests		1st test	Result: Abnormal	Result: Follow up
Urinalysis	Protein (+) (−)				Blood lipid	Total cholesterol (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/μL)					SGPT (U/L)			
	RBC (10^6/μL)				Hepatitis B	HbsAg			
	Platelet count (10^3/μL)					HbsAb			
	MCV (fl)				Other				
	Hct (%)※								

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	☐Other:_____	

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