

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	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.	
	Permanent address						Cell phone No.	
	Mailing address	<i>If different from above:</i>						
	Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.	Attach photo here	

Health Information	Medical History	Details of particular item/s or other matters requiring attention
	Please tick any of the following ailments you have had (<i>please add details for 13. to 18.</i>):	<input type="checkbox"/> Details given in the attached file.
	<input type="checkbox"/> 1. None <input type="checkbox"/> 7. Epilepsy <input type="checkbox"/> 13. Psychological or mental illness: _____ <input type="checkbox"/> 2. Tuberculosis <input type="checkbox"/> 8. SLE (Lupus) <input type="checkbox"/> 14. Cancer: _____ <input type="checkbox"/> 3. Heart disease <input type="checkbox"/> 9. Hemophilia <input type="checkbox"/> 15. Thalassemia: _____ <input type="checkbox"/> 4. Hepatitis <input type="checkbox"/> 10. G6PD deficiency <input type="checkbox"/> 16. Major surgery: _____ <input type="checkbox"/> 5. Asthma <input type="checkbox"/> 11. Arthritis <input type="checkbox"/> 17. Allergy to: _____ <input type="checkbox"/> 6. Kidney disease <input type="checkbox"/> 12. Diabetes mellitus <input type="checkbox"/> 18. Other: _____	
	<input type="checkbox"/> Holder of Catastrophic Illness Certificate - Category: _____ <input type="checkbox"/> Holder of Physical/Mental Disability Manual - Category: _____ Level: <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> 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 (<i>not including weekends, or days off</i>)?: <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 many days did you eat breakfast during the past 7 days (<i>not including weekends, or days off</i>)?: <input type="checkbox"/> ① Never <input type="checkbox"/> ② Seldom: _____ days <input type="checkbox"/> ③ Every day at (time)? _____ 3. During the past month (<i>not including weekends, days off, or winter or summer vacation</i>), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: <input type="checkbox"/> ① Yes <input type="checkbox"/> ② No 4. <u>During the past month, did you smoke?</u> : <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # cigarettes per day <input type="checkbox"/> ④ Quit 5. During the past month, did you drink alcohol? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # glasses per day <input type="checkbox"/> ④ Quit (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? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day, _____ # quids per day <input type="checkbox"/> ④ Quit	7. Do you feel worried or depressed ? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 8. Do you regularly feel chest discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 9. Do you regularly feel stomach discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 10. Do you regularly have headaches? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 11. Menstrual history (<i>women only</i>): (1) Your age at first menstruation: <input type="checkbox"/> ① Haven't begun menstruation yet <input type="checkbox"/> ② Age at first period: _____ (2) Length of menstrual cycle: <input type="checkbox"/> ① ≤ 20 days <input type="checkbox"/> ② 21-40 days <input type="checkbox"/> ③ ≥ 41 days <input type="checkbox"/> ④ irregular (<i>differing in length by more than 7 days</i>) (3) Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain 12. Bowel habits: During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once every 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 13. Internet use: During the past seven days (<i>not including weekends, or days off</i>), how many hours did you use the internet every day, apart from when doing homework or in class? <input type="checkbox"/> ① ≤ 1 hour <input type="checkbox"/> ② 1-2 (less than) hours <input type="checkbox"/> ③ 2-4 (less than) hours <input type="checkbox"/> ④ 4-5 (less than) hours <input type="checkbox"/> ⑤ ≥ 5 hours
-----------	---	--

Self-rated Health	1. In general, during the past month, would you say your health 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. In general, during the past month, would you say your mental health 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? Please give details:

Health Examination Record (to be completed by medical personnel)				Date: Year _____ Month _____ Day _____								Examiner's Signature																																																			
Height: _____ cm Weight: _____ kg				Optional <input type="checkbox"/> Waistline: _____ cm																																																											
Blood Pressure: _____ / _____ mmHg Pulse rate: _____ /min																																																															
Vision: Uncorrected: Left _____ Right _____ Corrected: Left _____ Right _____																																																															
Eyes		<input type="checkbox"/> Normal		<input type="checkbox"/> Color blindness <input type="checkbox"/> Other: _____																																																											
ENT		<input type="checkbox"/> Normal		Hearing abnormality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Suspected otitis media (<i>further diagnosis required</i>), such as from a perforated ear drum <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: _____																																																											
Genitourinary system		<input type="checkbox"/> Normal <input type="checkbox"/> Not checked		<input type="checkbox"/> Abnormal foreskin <input type="checkbox"/> Varicocele <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		<input type="checkbox"/> Normal		<input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Calculus <input type="checkbox"/> Gingivitis <input type="checkbox"/> Periodontitis <input type="checkbox"/> Dental malocclusion <input type="checkbox"/> Abnormal Oral Mucosa <input type="checkbox"/> Other: _____																																																											
Dentition status: C-cavity; X-missing; Δ- filled; ψ- impacted tooth; Sp.- supernumerary tooth																																																															
Upper Right		<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <tr><td>18</td><td>17</td><td>16</td><td>15</td><td>14</td><td>13</td><td>12</td><td>11</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr> <tr><td>48</td><td>47</td><td>46</td><td>45</td><td>44</td><td>43</td><td>42</td><td>41</td><td>31</td><td>32</td><td>33</td><td>34</td><td>35</td><td>36</td><td>37</td><td>38</td></tr> <tr><td> </td><td> </td></tr> </table>												18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38																	Upper left	
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28																																																
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38																																																
Lower Right														Lower Left																																																	
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																																																					
Laboratory Tests		1 st test	Result		Laboratory Tests				1 st test	Result																																																					
			Abnormal	Follow up						Abnormal	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: <input type="checkbox"/> No obvious abnormality <input type="checkbox"/> R/O TB <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> 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																																																													