

**National Changhua University of Education Student Health Examination**  
**Form Ministry of Education, Taiwan, R.O.C.**

Student No.	
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Basic Information	Date of Entry	(mm)/(yy) /	Dept./Institute/Program			Name		
	Date of Birth	(dd)/(mm)/(yy) / /	Blood Type		Gender	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.	
	Permanent address						Cell phone	
	Mail address	<input type="checkbox"/> As above					Student's E-mail	
	Emergency contact	Relationship	Name	Phone (home)	Phone (work)			

Health Information	Please tick of the 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"/> 2. Tuberculosis	<input type="checkbox"/> 7. Epilepsy
	<input type="checkbox"/> 3. Heart disease	<input type="checkbox"/> 8. SLE (Lupus)
	<input type="checkbox"/> 4. Hepatitis	<input type="checkbox"/> 9. Hemophilia
<input type="checkbox"/> 5. Asthma	<input type="checkbox"/> 10. G6PD deficiency	
<input type="checkbox"/> 11. Arthritis	<input type="checkbox"/> 12. Diabetes mellitus	
<input type="checkbox"/> 13. Psychological or mental illness: _____	<input type="checkbox"/> 14. Cancer:	
<input type="checkbox"/> 15. Thalassemia:	<input type="checkbox"/> 16. Major surgery: _____	
<input type="checkbox"/> 17. Allergy: _____	<input type="checkbox"/> 18. Other:	
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"/> ④ Never <input type="checkbox"/> ⑤ Some days: ___ days. <input type="checkbox"/> ⑥ 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"/> ⑦ 0 days <input type="checkbox"/> ⑧ 1 day <input type="checkbox"/> ⑨ 2 days <input type="checkbox"/> ⑩ 3 days <input type="checkbox"/> ⑪ 4 days <input type="checkbox"/> ⑫ 5 days <input type="checkbox"/> ⑬ 6 days <input type="checkbox"/> ⑭ 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"/> ③ a cigarettes <input type="checkbox"/> ④ e-cigarettes <input type="checkbox"/> ⑤ IQOS (multiple choice) <input type="checkbox"/> ⑥ Every day - please tick: <input type="checkbox"/> ③ a cigarettes <input type="checkbox"/> ④ e-cigarettes <input type="checkbox"/> ⑤ IQOS (multiple choice) <input type="checkbox"/> ⑦ 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"/> ④ 2 drinks or more <input type="checkbox"/> ⑤ 1 drink <input type="checkbox"/> ⑥ less than 1 drink <input type="checkbox"/> ⑦ 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	During the past month, would you say your health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor
	During the past month, would you say your mental health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor

Health Examination Record (to be completed by medical personnel)			Date: Day ____ Month _____ Year			Examiner's Signature				
Height: _____ cm Weight: _____ kg			□Waistline: _____ cm							
Blood Pressure: ____/____ mmHg Pulse rate: ____/min										
Vision: Uncorrected: Right _____ Left _____ Corrected: Right _____ Left _____										
Eyes	□Normal	□Color vision deficiency □Other:								
ENT	□Normal	Hearing abnormality: □Left □Right □Suspected otitis media, 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	□Abnormal swelling □Other:								
Spine & limbs	□Normal	□Scoliosis □Limb deformity □Difficulty squatting □Other:								
Urogenital system △	□Normal □Not checked	□Abnormal foreskin □Varicocele □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								
Summary	□Normal □Requires a consultation with : □Other:						Stamp of hospital/clinic where examination was done			
Laboratory Tests		1 <sup>st</sup> test	Result		Laboratory Tests		1 <sup>st</sup> test	Result		
			Abnormal	Follow up				Abnormal	Follow up	
Urinaly- sis	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 <sup>3</sup> /μL)					SGPT (U/L)				
	RBC (10 <sup>6</sup> /μL)				Hepatitis B	HBsAg				
	Platelet count (10 <sup>3</sup> /μL)					Anit-HBs				
	MCV (fl)				Other※					
	Hct (%)									
Chest X-ray	Date of X-ray	Result: □No obvious abnormality □R/O TB □TB-related Calcification □Abnormal thorax □Pleural cavity edema □Scoliosis □Cardiomegaly □Bronchiectasis □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									