School Name____ISU____Student Health Examination Form

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

Student ID	

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

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 in either eye? ☐0. No ☐1. Yes ☐2.UnknownHigh myopia: Do you currently have myopia greater than 500 degrees in either eye? ☐0. No ☐1. Yes ☐2.Unknown

Holder of Catastrophic Illness (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 these diseases have not yet healed or still under treatment, please provide medical record as care reference.

Family medical history:

Relative with hereditary disease ☐0. No ☐1. Yes name of disease ☐2.unknown

Relatives of family members suffering from major genetic diseases:_____

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)? ☐⓪Never ☐① Some days, _____days. ☐②Every day (Eat before 9:00 ☐Yes ☐No; Eat after 9:00 ☐Yes ☐No)

3.During the past 7 days, how many days did you do moderate-intensity exercise, such as sports, fitness, transportation, and recreational physical activities for at least 10 minutes each time per day? ☐⓪0 days ☐① day ☐②2 days ☐③ 3 days ☐④ 4 days ☐⑤ 5 days ☐⑥ 6 days ☐⑦ 7 days

4.During the past month, did you use tobacco (including cigarette, e-cigarettes and iQOS)? ☐①Not at all ☐② Some days（☐ⓐcigarette、☐ⓑe-cigarettes、☐ⓒiQOS） ☐③ Every day（☐ⓐcigarette、☐ⓑe-cigarettes、☐ⓒiQOS） ☐④ Quit

5.During the past month, did you drink alcohol? ☐①Not at all ☐②Some days ☐③Every day (☐ⓐ2 drinks or more ☐ⓑ1 drink ☐ⓒless than 1 drink) ☐④Quit

(Note: please tick how many drinks, 'standard drink' means: beer 330 ml, wine 120 ml, liquor 45 ml)

6. During the past month, did you chew betel quid? ☐①Not at all ☐②Some days ☐③Every day ☐④Quit

7. Do you feel depressed? ☐⓪Not at all ☐① Sometimes ☐②Often

8. Do you feel worried? ☐⓪Not at all ☐① Sometimes ☐②Often

9. During the past 7 days, how often did you defecate? ☐① At least once every 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 every day, apart from when doing homework or in class? ☐①less than 2 hours ☐② 2-4 hours ☐③4 hours or more, ___ hours

11. How many times do you usually brush your teeth a day? ☐⓪None ☐①1 time ☐②2 times ☐③3 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 ☐② Once a year ☐③ More than one year ☐④ Never

13. Menstrual history (women only): Do you have painful menstrual periods? ☐①No ☐② Light pain ☐③ Severe pain ☐④ Unknown/Refused

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: ☐0. No ☐1. Yes:_____ , do you need school assistance: ☐0. No ☐1. Yes:

Health Examination Record (to be completed by medical personnel)	Date: Year_____ Month_____ Day_____	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 blindness ☐Other:_____	
ENT	☐Normal	Hearing abnormality: ☐Left ☐Right	
	☐Normal	☐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 Health Screening	☐Normal	Untreated caries: ☐0.No ☐1.Yes Missing tooth (been extracted due to caries) : ☐0.No ☐1.Yes Filled tooth (been filled due to caries, including crown, inlay etc.) : ☐0. No ☐1. Yes Gingivitis: ☐0. No ☐1. Yes Dental calculus or tartar: ☐0.No ☐1.Yes ☐Poor oral hygiene ☐Malocclusion ☐Others:_____	

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

Laboratory Tests		1st test	Result		Laboratory Tests		1st test	Result	
			Abnormal	Follow up				Abnormal	Follow up
Urinalysis	Protein (+) (−)				Renal function	Creatinine (mg/dl)			
	Sugar (+) (−)					UA (mg/dl)			
	O.B. (+) (−)				Blood lipid	Total cholesterol (mg/dl)			
	pH					TG (mg/dl)			
Blood test	Hb (g/dl)					HDL-C (mg/dl)			
	WBC (10^3/μL)				Liver function	SGOT (AST)(U/L)			
	RBC (10^6/μL)					SGPT (ALT) (U/L)			
	Platelet count (10^3/μL)				Hepatitis B	HBsAg			
	MCV (fl)					Anti-HBs			

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 ☐Pulmonary infiltrates ☐Solitory pulmonary nodule ☐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