Southern Taiwan University Of Science Technology Student Health Examination Form

<table>
<tr><td>Name</td><td></td><td>Gender</td><td>○Male ○Female</td><td>Date of Birth</td><td colspan="9">YYYY/MM/DD</td><td rowspan="7">Please attach a 2 inch Head shot</td></tr>
<tr><td>Student ID</td><td></td><td colspan="3">Passport number</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Class & Dept.</td><td rowspan="2"></td><td>Home number</td><td colspan="11"></td></tr>
<tr><td>Mobile number</td><td colspan="11"></td></tr>
<tr><td>Contact address</td><td colspan="13"></td></tr>
<tr><td rowspan="2">Emergency Contact</td><td></td><td rowspan="2">Relation</td><td></td><td rowspan="2">Phone number</td><td colspan="9"></td></tr>
<tr><td></td><td></td><td colspan="9"></td></tr>
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<tr><td>Health Check and Information Survey Agreement of Consent</td><td>Dear parents and students
According to law, students need to go through a health check once admitted to school. But if students or parents do not consent with the check, they can go do health checks outside of the school's health check. In order to help the students with health the school needs to collect the information provided on this card and/or other information. You have the right to alter,delete,collect,process,use…etc on this card , to do so please contact 【06-2533131 #2231】
I, ______(Please sign here)______ hereby agree to the above agreement of consent</td></tr>
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<table>
<tr><td rowspan="2">Basic health information</td><td>Personal medical history: Please check all that apply
1. □None 7. □Epilepsy 13. □Thalassemia:______________________________
2. □Tuberculosis 8. □SLE (Lupus) 14. □Cancer:___________________________________
3. □Heart disease 9. □Hemophilia 15. □Psychological or mental illness:_____________
4. □Hepatitis 10.□G6PD deficiency 16. □Major surgery:___________________________
5. □Asthma 11. □Arthritis 17. □Allergy to:_______________________________
6. □Kidney disease 12. □Diabetes mellitus 18.Other:_____________________________________</td></tr>
<tr><td>□Current Holder ○Used To Be Holer 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: relative with hereditary disease Name of disease</td></tr>
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<table>
<tr><td>Lifestyle</td><td>Tick the box that best applies:
1. How much did you sleep during the past 7 days:□≧7 hours a day □<7 hours a day □I suffer from insomnia
2. How many days did you eat breakfast during the past 7 days: □Never□Seldom:__days□Every day at __(time)__
3. During the past monthhave you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: □Yes □No
4. During the past month, did you smoke?: □No □Often □Every day:____ cigarettes per day □Quit
5. During the past month, did you drink alcohol? □No□Often □Every day: ___glasses per day□Quit
6. During the past month, did you chew betel quid?□No □Often □Every day, ____ quids per day □Quit
7. Do you feel worried or depressed？□No □Seldom □Often
8. Do you regularly feel chest discomfort? □No □Seldom □Often
9. Do you regularly feel stomach discomfort?□No □Seldom □Often
10. Do you regularly have headaches? □No □Seldom □Often
11.Menstrual history (women only):
(1)Your age at first menstruation: □Haven't begun menstruation yet □Age at first period:
(2)Length of menstrual cycle:□≦20 days□21-40 days□≧41 days□irregular (differing by more than 7days)
(3)Do you have painful menstrual periods? □No □Light pain □Severe pain
12. Defecation habit：How often in the past 7 days？ □At least once a day □two days □three days</td></tr>
<tr><td rowspan="2">Self evaluation</td><td>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</td></tr>
<tr><td>※ Do you currently have any health concerns? Please give details:_______________________________________
____</td></tr>
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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____			
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 ☐Bowlegged (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	☐Normal ☐Requires a consultation with a:_____ ☐Other:_____	Stamp of hospital/clinic where examination was done

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: ☐No obvious abnormality ☐R/O TB ☐TB-related Calcification ☐Abnormal thorax ☐Pleura 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