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| **Chung Cheng University Student Health Examination Form** | Enrollm ent Date | mm/yyyy / |
| Basic Information | .Name |  | Dept./Institute/Program |  | Student No |  |
| Date of Birth | dd/mm/yyyy / / | Blood Type |  | Gender | □ M □ F | I.D. No. |  |  |  |  |  |  |  |  |  |  |
| Permanent address |  | Cell phone |
| Mail address | □As above |  |
| Emergency contact | Relationship | Name | Phone (home) | Phone (work) | Student’s E-mail |
|  |  |  |  |  |
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| Health Information | Please tick of the ailments you have had (please add details for 13. to 18.): |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. None
* 2. Tuberculosis
* 3. Heart disease
* 4. Hepatitis
* 5. Asthma
 | * 6. Kidney disease
* 7. Epilepsy
* 8. SLE (Lupus)
* 9. Hemophilia

□10. G6PD deficiency | * 11. Arthritis
* 12. Diabetes mellitus
* 13. Psychological or mental illness:
* 14. Cancer:
* 15. Thalassemia:
 | * 16. Major surgery:
* 17. Allergy:
* 18. Other:
 |
| High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye?□0. No □1. Yes □2.Unknown |
| Holder of Catastrophic Illness (including 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 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: □0. No □1. Yes, Name of disease □2.UnknownRelatives 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*)?

□≥7 hours a day □<7 hours a day □I suffer from insomnia.1. How often did you eat breakfast in the past 7 days *(not including weekends, or days off*)?

□Never □Some days: days. □Every day (Eat: before 9:00 □Yes □No; after 9:00 □Yes □No )1. 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? □0 day □1 day □2 days □3 days □4 days □5 days □6 days □7 days
2. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? □Not at all

□Some days -please tick: □ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice)□Every day - please tick: □ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice) □I have quit1. During the past month, did you drink alcohol? □Not at all □Some days

□ Every day - please tick how many: □ⓐ2 drinks or more □ⓑ1 drink □ⓒless than 1 drink □I have quit (Note: 1 ‘drink’ means: 330 ml of beer, 120 ml of wine, 45 ml of spirits)1. During the past month, did you chew betel nut? □Not at all □Some days □Every day □ I have quit
2. Do you feel depressed? □Not at all □Sometimes □Often
3. Do you feel worried? □Not at all □Sometimes □Often
4. During the past 7 days, how often did you defecate?

□At least once a day □Once in 2 days □Once in 3 days □ Once in 4 or more days1. 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? □less than 2 hours □2-4 hours □4 hours or more: hours
2. How many times do you usually brush your teeth a day? □None □Once □Twice □3 or more times
3. How often do you have a dental checkup even if there’s notoothache or other oral discomfort?

□Once every 6 months □Once a year □More than one year □Never1. Menstrual cycle – *female students*: Do you have painful menstrual periods?

□No □Light pain □Severe pain □ Unknown/Declined to answer |
| Health Self – | 1. During the past month, would you say your health condition is □Excellent □Good □Average □Fair □Poor
2. During the past month, would you say your mental health condition is □Excellent □Good □Average □Fair □Poor
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| ※ Do you currently have any health concerns? □0. No □1. Yes※ Do you need the university/college to provide any assistance? □0. No □1. Yes   |

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| 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: |
| Skin | □ | Normal | □Ringworm □Scabies □Wart □Atopic dermatitis □Eczema □Other: |
| Oral Health Screening | □ | Normal | Untreated caries: □0.No □1.YesMissing tooth (been extracted due to caries): □0.No □1.Yes Filled tooth : □0. No □1. YesGingivitis: □0. No □1. YesDental calculus or tarta: □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 | 1st test | Result | Laboratory Tests | 1st test | Result |
| Abnormal | Follow up | Abnormal | Follow up |
| Blood test | Hb (g/dL) |  |  |  | Urinalysis | Protein (＋) (－) |  |  |  |
| WBC (103/μL) |  |  |  | Sugar (＋) (－) |  |  |  |
| RBC (106/μL) |  |  |  | O.B. (＋) (－) |  |  |  |
| Platelet count(103/μL) |  |  |  | pH |  |  |  |
| MCV (fl） |  |  |  | Liver function | SGOT (AST)（U/L） |  |  |
|  |
| HcT (%)  |  |  |  | SGPT (ALT)（U/L） |  |  |  |
| Renal function | Creatinine (mg/dL) |  |  |  | Blood lipids | Total cholesterol (mg/dL) |  |  |  |
| UA (mg/dL) |  |  |  | Other | Blood glucose (mg/dL) |  |  |  |
| BUN (mg/dL)  |  |  |  |  |  |  |  |  |
| Chest X-ray | Date of X-ray | Result:□No obvious abnormality□Abnormal thorax□Cardiomegaly□Solitary pulmonary nodule | □R/O TB□Pleural cavity edema□Bronchiectasis | □TB-related calcification□Scoliosis□Pulmonary infiltrates□Other: | Further treatment, date, and comment: |
|  |
| Other tests | Item |  Date | Checked by | Result | Follow-up referral and notes: |
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| Summary | Summary of health examination results, for follow-up or treatment, and case management outline |

JAN/2023