

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	☐ 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.	Attach photo here											

Health Information	Medical History Please tick any of the following ailments you have had (<i>please add details for 13. to 18.</i>): ☐ 1. None ☐ 7. Epilepsy ☐ 13. Psychological or mental illness: _____ ☐ 2. Tuberculosis ☐ 8. SLE (Lupus) ☐ 14. Cancer: _____ ☐ 3. Heart disease ☐ 9. Hemophilia ☐ 15. Thalassemia: _____ ☐ 4. Hepatitis ☐ 10. G6PD deficiency ☐ 16. Major surgery: _____ ☐ 5. Asthma ☐ 11. Arthritis ☐ 17. Allergy to: _____ ☐ 6. Kidney disease ☐ 12. Diabetes mellitus ☐ 18. Other: _____						Details of particular item/s or other matters requiring attention ☐ Details given in the attached file.					
	☐ Holder 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.											
	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>)?: ☐ 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 (<i>not including weekends, or days off</i>)?: ☐ ①Never ☐ ②Seldom: _____ days ☐ ③Every 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?: ☐ ①Yes ☐ ②No 4. <u>During the past month, did you smoke?</u> : ☐ ①No ☐ ②Often ☐ ③Every day: _____ # cigarettes per day ☐ ④Quit 5. During the past month, did you drink alcohol? ☐ ①No ☐ ②Often ☐ ③Every day: _____ # glasses per day ☐ ④Quit (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? ☐ ①No ☐ ②Often ☐ ③Every day, _____ # quids per day ☐ ④Quit						7. Do you feel worried or depressed ? ☐ ①No ☐ ②Seldom ☐ ③Often 8. Do you regularly feel chest discomfort? ☐ ①No ☐ ②Seldom ☐ ③Often 9. Do you regularly feel stomach discomfort? ☐ ①No ☐ ②Seldom ☐ ③Often 10. Do you regularly have headaches? ☐ ①No ☐ ②Seldom ☐ ③Often 11. Menstrual history (<i>women only</i>): (1) Your age at first menstruation: ☐ ①Haven't begun menstruation yet ☐ ②Age at first period: _____ (2) Length of menstrual cycle: ☐ ① ≤ 20 days ☐ ②21-40 days ☐ ③ ≥ 41 days ☐ ④irregular (<i>differing in length by more than 7 days</i>) (3) Do you have painful menstrual periods? ☐ ①No ☐ ② Light pain ☐ ③ Severe pain 12. Bowel habits: During the past 7 days, how often did you defecate? ☐ ①At least once every day ☐ ②Once in 2 days ☐ ③Once in 3 days ☐ ④Once 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? ☐ ① ≤ 1 hour ☐ ②1-2 (less than) hours ☐ ③2-4 (less than) hours ☐ ④4-5 (less than) hours ☐ ⑤ ≥ 5 hours					
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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:											

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 (<i>further diagnosis required</i>), 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; Δ- 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		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: ☐ No obvious abnormality ☐ R/O TB ☐ TB-related Calcification ☐ Abnormal thorax ☐ Pleura cavity edema ☐ Scoliosis ☐ Cardiomegaly ☐ Bronchiectasis ☐ Other:_____	Further treatment, date, and comment:
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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
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