Tainan University of Technology Student Health Examination Form

Student No.		Passport No.		Attach photo here Back fill:Name、Student ID、Department
Name		□Male □Female	Blood Type □A □B □O □AB	
Department		Nationality		
Date of Birth	(yyyy)/ (mm)/ (dd)		Student's mobile phone	
Permanent add				
Mailing add				

Emergency contact (Parents or guardian or Relatives and friends nearby)	Name	Relationship	Phone (home、work)	Mobile No.

Health information

一、Medical History：Please tick any of the following ailments you have had

□1. None □2. Diabetes mellitus □3. Arthritis □4. Kidney disease □5. Heart disease
□6.Hepatitis □7. Asthma □8. Epilepsy □9. SLE (Lupus) □10.Hemophilia
□11.Thalassemia , □Heavy □Medium □Light □12.G6PD □13.Tuberculosis □14.Cancer_____
□15.Psychological or mental illness：_____ □16.Allergy：_____
□17.Major surgery:_____、date_____□18.Metabolic syndrome □19.Other_____
*Special disease status or matters needing attention: □ No □ Yes (Please describe):_____
*Whether to take long-term medication□ No □ 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.

High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye?
□No □Yes □Unknow

二、Holder of Catastrophic Illness (including Rare Disease) Certificate: □No □Yes , Category: _____

三、Holder of Physical/Mental Disability Manual:□No □Yes , Category: _____ Level:□1.Mild□2.Moderate□3.Severe□4 Profound

四、Family medical/disease history:□ Unknow □No □Yes
Relatives of family members suffering from major hereditary disorder: _____ Name of disease: _____

Regular Life-style

*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
2.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)
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? □0days □1day □2days □3days □4days □5days □6days □7days
4.During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)?□ Not at all □ I have quit □ Some days -please tick:□ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice) □ Every day - please tick: □ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice)
5.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 1drink) □ 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? □ Not at all □ Some days □ Every day □ I have quit
7.Do you feel depressed? □ Not at all □ Sometimes □ Often
8.Do you feel worried? □ Not at all □ Sometimes □ Often
9.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 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? □ less than 2 hours □ 2-4 hours □ 4 hours or more:___hours
11.How many times do you usually brush your teeth a day? □ None □ Once □ Twice □ 3 or more times
12.How often do you have a dental checkup even if there's no toothache or other oral discomfort?□ Once every 6 months □ Once a year □ More than one year □ Never
13.Menstrual cycle–*female students*: Do you have painful menstrual periods?□ No □ Light pain □ Severe pain □ Unknown/Declined to answer

Health Self：
During the past month, would you say your health condition is □Excellent □Good □Average □Fair □Poor
During the past month, would you say your mental health condition is □Excellent □Good □Average □Fair □Poor
※Do you currently have any health concerns? □No □Yes (Please describe):_____
※Do you need the university/college to provide any assistance? □No □Yes(Please describe):_____

1.Do you need to agree to the medical, health and use group within the scope of the school to agree to the health and processing and use of health checks Collect and analyze and manage the database and data, complete the results of the health check,carry out the guidance work and check the results of the students health management? □Yes □No
2.Do you agree that the health care team, on the premise of respecting personal privacy, will refer the physical examination results to relevant units for follow-up counseling and care according to the needs of counseling and medical treatment? □Yes □No

The person who signed the consent：_____(Under the age of 18, please have the signature of the legal representative)
Date：_____(yyyy)/_____(mm)/_____(dd)

Health Examination Record(to be completed by medical personnel)

Date: (yyyy)/ (mm)/ (dd)					Examiner's Signature
Height:_____cm；Weight:_____kg；BMI：_____kg/m^2；Waistline:_____cm					
Blood Pressure:_____ /_____ mmHg；Pulse rate：_____/min					
Vision	Uncorrected	Right： Left：	Corrected	Right： Left：	
Eyes	□Normal	□Other _____			
ENT	□Normal	Hearing abnormality: □Left □Right □Suspected otitis media □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	Untreated caries: □No □Yes Missing tooth (been extracted due to caries): □No □Yes Filled tooth: □No □Yes □Poor oral hygiene □Malocclusion □Other_____ □Normal				
Chest X-ray	□No obvious abnormality □R/O TB □TB-related Calcification □Abnormal thorax □Pleural cavity edema □Scoliosis □Cardiomegaly □Bronchiectasis □Pulmonary infiltrates □Lung nodules □Other___				

Laboratory Tests		Result	Laboratory Tests		Result
Blood test	RBC（10^6/μL）		Urinalysis	Protein (+)(-)	
	WBC (10^3/μL)			Sugar (+)(-)	
	Hb (g/dL)			O.B(+)(-)	
	Platelet count（10^3/μL）			pH	
	MCV(fl)		Renal function	Creatinine（mg/dL）	
Liver function	SGOT(AST)（U/L）			UA（mg/dL）	
	SGPT(ALT)（U/L）		Blood lipid	Total cholesterol (mg/dl)	
Blood Glucose	Fasting Plasma Glucose(mg/dL)			Triglycerides(mg/dl)	
				High-DensityLipoprotein (mg/dl)	
Referred for follow-up, comment			Stamp of hospital/ clinic where examination was done		