

# 大專校院學生健康資料卡英文版

School Name \_\_\_\_\_ Student Health Examination Form  
Ministry of Education, Taiwan, R.O.C. (Revised Version)

Student No.	
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Contact Information	Date of Entry	(yy)/(mm)/	Dept./Institute/Class					Name							
	Date of Birth	(yy)/(mm)/(dd)/	Blood Type		Sex	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.								
	Permanent address								Cell phone No.		Attach photo here				
	Mailing address	If different from above:													
	Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.									

Health Information	Medical History							Details of particular item/s or other matters requiring attention						
	Please tick any of the following ailments you have had ( <i>please add details for 13. to 18.</i> ):							<input type="checkbox"/> Details given in the attached file.						
	<input type="checkbox"/> 1. None	<input type="checkbox"/> 7. Epilepsy	<input type="checkbox"/> 13. Psychological or mental illness:_____											
	<input type="checkbox"/> 2. Tuberculosis	<input type="checkbox"/> 8. SLE (Lupus)	<input type="checkbox"/> 14. Cancer:_____											
	<input type="checkbox"/> 3. Heart disease	<input type="checkbox"/> 9. Hemophilia	<input type="checkbox"/> 15. Thalassemia:_____											
	<input type="checkbox"/> 4. Hepatitis	<input type="checkbox"/> 10. G6PD deficiency	<input type="checkbox"/> 16. Major surgery:_____											
	<input type="checkbox"/> 5. Asthma	<input type="checkbox"/> 11. Arthritis	<input type="checkbox"/> 17. Allergy to: ....._____											
	<input type="checkbox"/> 6. Kidney disease	<input type="checkbox"/> 12. Diabetes mellitus	<input type="checkbox"/> 18. Other:_____											
	<input type="checkbox"/> Holder of Catastrophic Illness Certificate - Category:_____													
	<input type="checkbox"/> Holder of Physical/Mental Disability Manual - Category:_____													
	Level: <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> 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> )?: <input type="checkbox"/> ① ≥ 7 hours a day <input type="checkbox"/> ② < 7 hours a day <input type="checkbox"/> 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> )?: <input type="checkbox"/> ① Never <input type="checkbox"/> ② Seldom: _____ days <input type="checkbox"/> ③ Every 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?: <input type="checkbox"/> ① Yes <input type="checkbox"/> ② No 4. During the past month, did you smoke?: <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # cigarettes per day <input type="checkbox"/> ④ Quit 5. During the past month, did you drink alcohol? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # glasses per day <input type="checkbox"/> ④ Quit (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? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day, _____ # quids per day <input type="checkbox"/> ④ Quit							7. Do you feel worried or depressed ? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 8. Do you regularly feel chest discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 9. Do you regularly feel stomach discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 10. Do you regularly have headaches? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 11. Menstrual history ( <i>women only</i> ): (1) Your age at first menstruation: <input type="checkbox"/> ① Haven't begun menstruation yet <input type="checkbox"/> ② Age at first period: _____ (2) Length of menstrual cycle: <input type="checkbox"/> ① ≤ 20 days <input type="checkbox"/> ② 21-40 days <input type="checkbox"/> ③ ≥ 41 days <input type="checkbox"/> ④ Irregular ( <i>differing in length by more than 7 days</i> ) (3) Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain 12. Bowel habits: During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once every day <input type="checkbox"/> ② Once in 2 days <input type="checkbox"/> ③ Once in 3 days <input type="checkbox"/> ④ Once 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? <input type="checkbox"/> ① ≤ 1 hour <input type="checkbox"/> ② 1-2 (less than) hours <input type="checkbox"/> ③ 2-4 (less than) hours <input type="checkbox"/> ④ 4-5 (less than) hours <input type="checkbox"/> ⑤ ≥ 5 hours						
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Self-rated Health	1. In general, during the past month, would you say your health is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor 2. In general, during the past month, would you say your mental health is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Very good <input type="checkbox"/> ③ Good <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor													
	※ 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 <input type="checkbox"/> Waistline:_____cm															
Blood Pressure:_____/_____/____mmHg    Pulse rate:_____/min																			
Vision:    Uncorrected: Left_____ Right_____    Corrected: Left_____ Right_____																			
Eyes	<input type="checkbox"/> Normal		<input type="checkbox"/> Color blindness <input type="checkbox"/> Other:_____																
ENT	<input type="checkbox"/> Normal		Hearing abnormality: <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Suspected otitis media ( <i>further diagnosis required</i> ), such as from a perforated ear drum <input type="checkbox"/> Swollen tonsils <input type="checkbox"/> Earwax embolism <input type="checkbox"/> Other:_____																
Head & Neck	<input type="checkbox"/> Normal		<input type="checkbox"/> Wry neck (torticollis) <input type="checkbox"/> Abnormal mass <input type="checkbox"/> Other:_____																
Chest	<input type="checkbox"/> Normal		<input type="checkbox"/> Cardiopulmonary disease <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Other:_____																
Abdomen	<input type="checkbox"/> Normal		<input type="checkbox"/> Abnormally swollen <input type="checkbox"/> Other:_____																
Spine & limbs	<input type="checkbox"/> Normal		<input type="checkbox"/> Scoliosis <input type="checkbox"/> Limb deformity <input type="checkbox"/> Bowlegged (Difficulty squatting) <input type="checkbox"/> Other:_____																
Genitourinary system	<input type="checkbox"/> Normal <input type="checkbox"/> Not checked		<input type="checkbox"/> Abnormal foreskin <input type="checkbox"/> Varicocele <input type="checkbox"/> Other:_____																
Skin	<input type="checkbox"/> Normal		<input type="checkbox"/> Ringworm <input type="checkbox"/> Scabies <input type="checkbox"/> Wart <input type="checkbox"/> Atopic dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Other:_____																
Oral	<input type="checkbox"/> Normal		<input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Calculus <input type="checkbox"/> Gingivitis <input type="checkbox"/> Periodontitis <input type="checkbox"/> Dental malocclusion <input type="checkbox"/> Abnormal Oral Mucosa <input type="checkbox"/> 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		<input type="checkbox"/> Normal <input type="checkbox"/> Requires a consultation with a: _____ <input type="checkbox"/> Other: _____										Stamp of hospital/clinic where examination was done							

Laboratory Tests		1 <sup>st</sup> test	Result		Laboratory Tests		1 <sup>st</sup> 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 <sup>3</sup> /μL)					SGPT (U/L)			
	RBC (10 <sup>6</sup> /μL)				Hepatitis B	HbsAg			
	Platelet count (10 <sup>3</sup> /μL)					HbsAb			
	MCV (fl)				Other				
	Hct (%)※								
Chest X-ray	Date of X-ray	Result: <input type="checkbox"/> No obvious abnormality <input type="checkbox"/> R/O TB <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> 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							

