

Basic Information	Enrollment Date	(mm)/(yy) /	Dept./Institute/Program				Name										
	Date of Birth	(dd)/(mm)/(yy) / /	Blood Type		Gender	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.										
	Permanent address							Cell phone									
	Mail address	<input type="checkbox"/> As above <input type="checkbox"/> As right :															
	Emergency contact	Relationship	Name		Phone (home)		Phone (work)										
Health Information	Please tick of the ailments you have had (please add details for 13. to 18.):																
	<input type="checkbox"/> 1. None					<input type="checkbox"/> 6. Kidney disease					<input type="checkbox"/> 11. Arthritis					<input type="checkbox"/> 16. Major surgery: _____	
	<input type="checkbox"/> 2. Tuberculosis					<input type="checkbox"/> 7. Epilepsy					<input type="checkbox"/> 12. Diabetes mellitus					<input type="checkbox"/> 17. Allergy: _____	
	<input type="checkbox"/> 3. Heart disease					<input type="checkbox"/> 8. SLE (Lupus)					<input type="checkbox"/> 13. Psychological or mental illness: _____					<input type="checkbox"/> 18. Other: _____	
	<input type="checkbox"/> 4. Hepatitis					<input type="checkbox"/> 9. Hemophilia					<input type="checkbox"/> 14. Cancer: _____						
	<input type="checkbox"/> 5. Asthma					<input type="checkbox"/> 10. G6PD deficiency					<input type="checkbox"/> 15. Thalassemia: _____						
High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. Unknown																	
Holder of Catastrophic Illness (including Rare Disease) Certificate: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes - Category: _____																	
Holder of Physical/Mental Disability Manual <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Category: _____																	
Level: <input type="checkbox"/> 1. Mild <input type="checkbox"/> 2. Moderate <input type="checkbox"/> 3. Severe <input type="checkbox"/> 4. Profound																	
Special disease status or matters needing attention: <input type="checkbox"/> 0. No <input type="checkbox"/> 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: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes, Name of disease _____ <input type="checkbox"/> 2. Unknown Relatives 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)? <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 often did you eat breakfast in the past 7 days (<i>not including weekends, or days off</i>)? <input type="checkbox"/> ① Never <input type="checkbox"/> ② Some days: _____ days. <input type="checkbox"/> ③ Every day (Eat: before 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> No; after 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> ① 0 days <input type="checkbox"/> ② 1 day <input type="checkbox"/> ③ 2 days <input type="checkbox"/> ④ 3 days <input type="checkbox"/> ⑤ 4 days <input type="checkbox"/> ⑥ 5 days <input type="checkbox"/> ⑦ 6 days <input type="checkbox"/> ⑧ 7 days																
	4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or IQOS)? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days - please tick: <input type="checkbox"/> a cigarettes <input type="checkbox"/> b e-cigarettes <input type="checkbox"/> c IQOS (multiple choice) <input type="checkbox"/> ③ Every day - please tick: <input type="checkbox"/> a cigarettes <input type="checkbox"/> b e-cigarettes <input type="checkbox"/> c IQOS (multiple choice) <input type="checkbox"/> ④ I have quit																
	5. During the past month, did you drink alcohol? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day - please tick how many: <input type="checkbox"/> a 2 drinks or more <input type="checkbox"/> b 1 drink <input type="checkbox"/> c less than 1 drink <input type="checkbox"/> ④ 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? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day <input type="checkbox"/> ④ I have quit																
	7. Do you feel depressed? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often																
	8. Do you feel worried? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often																
	9. During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once a 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																
	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? <input type="checkbox"/> ① less than 2 hours <input type="checkbox"/> ② 2-4 hours <input type="checkbox"/> ③ 4 hours or more: _____ hours																
	11. How many times do you usually brush your teeth a day? <input type="checkbox"/> ① None <input type="checkbox"/> ② Once <input type="checkbox"/> ③ Twice <input type="checkbox"/> ④ 3 or more times																
	12. How often do you have a dental checkup even if there's no toothache or other oral discomfort? <input type="checkbox"/> ① Once every 6 months <input type="checkbox"/> ② Once a year <input type="checkbox"/> ③ More than one year <input type="checkbox"/> ④ Never																
	13. Menstrual cycle – <i>female students</i> : Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain <input type="checkbox"/> ④ Unknown/Declined to answer																
Health Self-	1. During the past month, would you say your health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor																
	2. During the past month, would you say your mental health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor																
	※ Do you currently have any health concerns? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes ※ Do you need the university/college to provide any assistance? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes																

Health Examination Record (to be completed by medical personnel)				Date: Day _____ Month _____ Year _____		Examiner's Signature	
Height: _____ cm		Weight: _____ kg		<input type="checkbox"/> Waistline: _____ cm※			
Blood Pressure: _____ / _____ mmHg				Pulse rate: _____ /min ※			
Vision: _____		Uncorrected: Right _____ Left _____		Corrected: Right _____ Left _____			
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Color vision deficiency △ <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, 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"/> Abnormal swelling <input type="checkbox"/> Other: _____					
Spine & limbs	<input type="checkbox"/> Normal	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Limb deformity <input type="checkbox"/> Difficulty squatting <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 Health Screening	<input type="checkbox"/> Normal	Untreated caries: <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes Missing tooth (been extracted due to caries): <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes Filled tooth : <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Gingivitis※: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Dental calculus or tartar※: <input type="checkbox"/> 0.No <input type="checkbox"/> 1.Yes <input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Malocclusion <input type="checkbox"/> Other					
Laboratory Tests		1 st test	Result Abnormal	Laboratory Tests		1 st test	Result Abnormal
Urinalysis	Protein (+) (−)			Renal function	Creatinine (mg/dL)		
	Sugar (+) (−)				UA (mg/dL)		
	O.B. (+) (−)				BUN (mg/dL) ※		
	pH						
Blood test	Hb (g/dL)			Liver function	SGOT (AST) (U/L)		
	WBC (10 ³ /μL)				SGPT (ALT) (U/L)		
	RBC (10 ⁶ /μL)			Blood lipids	Total cholesterol (mg/dL)		
	Platelet count(10 ³ /μL)				triglyceride(mg/dL)		
						HDL-C(mg/dL)	
	MCV (fl)			Other	LDL-C(mg/dL)		
	HcT (%)				blood sugar (mg/dL)		
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"/> Pleural cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Pulmonary infiltrates <input type="checkbox"/> Solitary pulmonary nodule <input type="checkbox"/> Other: _____				Further treatment, date, and comment:	
Other tests	Item	Date	Checked by	Result	Follow-up referral and notes:		
Summary	<input type="checkbox"/> Normal <input type="checkbox"/> Requires a consultation with : <input type="checkbox"/> Other: _____						Stamp of hospital/clinic where examination was done
Summary	Summary of health examination results, for follow-up or treatment, and case management outline						