University/College Name National Yunlin University of Science and Technology

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

Student No.	

Basic Information

Enrollment Date	(mm)/(yy) /	Dept./Institute/Program				Name	
Date of Birth	(dd)/(mm)/(yy) / /	Blood Type		Gender	☐ M ☐ F	I.D. No.	
Permanent address						Cell phone	
Mail address	☐As above ☐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.):

☐ 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.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)?
   ☐①≥7 hours a day ☐②<7 hours a day ☐③I suffer from insomnia.
2. How often did you eat breakfast in the past 7 days *(not including weekends, or days off)*?
   ☐⓪Never ☐①Some days:___days. ☐②Every 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? ☐⓪0 days ☐①1 day ☐②2 days ☐③3 days ☐④4 days ☐⑤5 days ☐⑥6 days ☐⑦7 days
4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? ☐①Not at all
   ☐②Some days -please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice)
   ☐③Every day - please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice) ☐④I have quit
5. During the past month, did you drink alcohol? ☐①Not at all ☐②Some days
   ☐③ Every day - please tick how many: ☐ⓐ2 drinks or more ☐ⓑ1 drink ☐ⓒless than 1 drink ☐④I 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? ☐①Not at all ☐②Some days ☐③Every day ☐④ I have quit
7. Do you feel depressed? ☐⓪Not at all ☐①Sometimes ☐②Often
8. Do you feel worried? ☐⓪Not at all ☐①Sometimes ☐②Often
9. During the past 7 days, how often did you defecate?
   ☐①At least once a day ☐②Once in 2 days ☐③Once in 3 days ☐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? ☐①less than 2 hours ☐②2-4 hours ☐③4 hours or more:___hours
11. How many times do you usually brush your teeth a day? ☐⓪None ☐①Once ☐②Twice ☐③3 or more times
12. How often do you have a dental checkup even if there's no toothache or other oral discomfort?
    ☐①Once every 6 months ☐②Once a year ☐③More than one year ☐④Never
13. Menstrual cycle – *female students*: Do you have painful menstrual periods?
    ☐①No ☐②Light pain ☐③Severe pain ☐④ Unknown/Declined to answer

Health Self-

1.During the past month, would you say your health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor
2.During the past month, would you say your mental health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor

※ 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

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.Yes Missing tooth (been extracted due to caries): ☐0.No ☐1.Yes Filled tooth : ☐0. No ☐1. Yes Gingivitis※: ☐0. No ☐1. Yes Dental calculus or tartar※: ☐0.No ☐1.Yes ☐Poor oral hygiene ☐Malocclusion ☐Other

Laboratory Tests		1st test	Result Abnormal	Laboratory Tests		1st test	Result Abnormal
Urinalysis	Protein (+) (−)			Renal function	Creatinine (mg/dL)		
	Sugar (+) (−)				UA (mg/dL)		
	O.B. (+) (−)				BUN (mg/dL) ※		
	pH			Liver function	SGOT (AST) (U/L)		
Blood test	Hb (g/dL)				SGPT (ALT) (U/L)		
	WBC (10^3/μL)			Blood lipids	Total cholesterol (mg/dLt)		
	RBC (10^6/μL)				triglyceride(mg/dL)		
	Platelet count(10^3/μL)				HDL-C(mg/dL)		
					LDL-C(mg/dL)		
	MCV (fl)			Other	blood sugar (mg/dL)		
	HcT (%)						

Chest X-ray	Date of X-ray	Result:			Further treatment, date, and comment:
		☐No obvious abnormality	☐R/O TB	☐TB-related calcification	
		☐Abnormal thorax	☐Pleural cavity edema	☐Scoliosis	
		☐Cardiomegaly	☐Bronchiectasis	☐Pulmonary infiltrates	
		☐Solitary pulmonary nodule	☐Other:		

Other tests	Item	Date	Checked by	Result	Follow-up referral and notes:

Summary	☐ Normal ☐ Requires a consultation with : ☐ Other:	Stamp of hospital/clinic where examination was done
Summary	Summary of health examination results, for follow-up or treatment, and case management outline	

麻疹及德國麻疹之抗體陽性檢查報告或預防接種證明(二擇一)
Proof of Positive Measles and Rubella Antibody or Measles and Rubella Vaccination Certificates (alternative)

基 本 資 料/ Basic Data

姓 名 Name ：	**性別 Sex** ：☐ **男 / M** ☐ **女 / F**
國 籍 Nationality ：	**護 照 號 碼 Passport No.** ：
出生年月日 Date of Birth ：YYYY / MM / DD	

a. 抗體檢查/ Antibody Tests

麻疹抗體/ Measles Antibody ☐ 陽性/ Positive ☐ 陰性/ Negative ☐ 未確定/ Equivocal

德國麻疹抗體/ Rubella Antibody ☐ 陽性/ Positive ☐ 陰性/ Negative ☐ 未確定/ Equivocal

b. 預防接種證明/ Vaccination Certificates (證明文件應註明接種日期、接種院所及疫苗批號。如檢附幼時接種證明，其接種年齡必須大於1歲。/ The certificate should include the date of vaccination, the name of administering hospital or clinic and the batch no. of vaccine. If the childhood vaccination certificate is submitted, it is important to include the record of the vaccines administered only after one year of age.)

☐ 麻疹預防接種證明/ Measles Vaccination Certificate

☐ 德國麻疹預防接種證明/ Rubella Vaccination Certificate

c. ☐ 有接種禁忌，暫不適宜預防接種/ Having contraindications, not suitable for vaccination

負責醫檢師簽章/ Signature of Chief Medical Technologist：

負責醫師簽章/ Signature of Chief Physician：

醫院負責人簽章/ Signature of Superintendent：

日期/ Date of Examination：YYYY / MM / DD