

Kaohsiung Medical University Student Health Examination Form

(Please fill in this form in detail and sign at the bottom. Fill it again at the D.2.8.02 of WAC.)

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.									
	Mailing address	<i>If different from above:</i>						E-mail									
	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>): <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:						Special disease status or matters needing attention: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes (please describe): If the ailments listed on the left has not yet healed or still under treatment, please provide medical record as care reference					
	Holder of Catastrophic Illness (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											
	High myopia: Do you currently have myopia greater than 500 degrees in either eye? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2.Unknown											
	Family medical history: Relative with hereditary disease <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 genetic diseases: _____											

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"/> ① Some days, _____ days. <input type="checkbox"/> ② Every day (Eat before 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> No; Eat after 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> No) 3. During the past 7 days, how many days did you do moderate-intensity exercise, such as sports, fitness, transportation, and recreational physical activities for at least 10 minutes each time per day? <input type="checkbox"/> ① 0 days <input type="checkbox"/> ① 1 day <input type="checkbox"/> ② 2 days <input type="checkbox"/> ③ 3 days <input type="checkbox"/> ④ 4 days <input type="checkbox"/> ⑤ 5 days <input type="checkbox"/> ⑥ 6 days <input type="checkbox"/> ⑦ 7 days 4. During the past month, did you use tobacco (<i>including cigarette, e-cigarettes and IQOS</i>)? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Quit <input type="checkbox"/> ③ Some days (<input type="checkbox"/> ① cigarette 、 <input type="checkbox"/> ② e-cigarettes 、 <input type="checkbox"/> ③ IQOS) <input type="checkbox"/> ④ Every day (<input type="checkbox"/> ① cigarette 、 <input type="checkbox"/> ② e-cigarettes 、 <input type="checkbox"/> ③ IQOS) 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 (<input type="checkbox"/> ② drinks or more <input type="checkbox"/> ① drink <input type="checkbox"/> less than 1 drink) <input type="checkbox"/> ④ Quit (Note: please tick how many drinks, ‘standard drink’ means: beer 330 ml, wine 120 ml, liquor 45 ml)	6. During the past month, did you chew betel quid? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day <input type="checkbox"/> ④ 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 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 10. During the past 7 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 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 1 time <input type="checkbox"/> ③ 2 times <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 history (<i>women only</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/Refused
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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
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	※ Do you currently have any health concerns? Please give details: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes: _____, do you need school assistance: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes:
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Investigation of willingness	In compliance with the policy of teaching, counseling and related programs of medical health rules and regulations: do you agree that the school, under the premise of following Personal Information Protection Act and privacy respect, may collect, manage, make reasonable uses of your health information and forward it to the relevant division if counseling track and care are needed? Please sign if you agree with the statement above.
	※ Signature: _____ Date: _____ (yy/mm/dd) (For applicants who are below the age of 20, the signature of your guardian is required.)

For office use only.

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: Right _____ Left _____			Corrected: Right _____ Left _____						
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Color blindness△ <input type="checkbox"/> Other:							
ENT	<input type="checkbox"/> Normal	Hearing abnormality: <input type="checkbox"/> Right <input type="checkbox"/> Left <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 Health Screening	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 (been filled due to caries, including crown, inlay etc.): <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"/> Others								
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 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: <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"/> Pulmonary infiltrates <input type="checkbox"/> Solitary pulmonary nodule <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								

△ : The item can be examined as needed under the Implementation Regulations Regarding Students' Health Screening

※ : Optional item