National Taiwan Normal University Student Health Examination Form
Ministry of Education, Taiwan, R.O.C.

Student No.	

Contact Information

Date of Entry	(yy)/(mm) /	Dept./Institute/Class				Name	
Date of Birth	(yy)/(mm)/(dd) / /	Blood Type		Sex	☐M ☐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

Please tick any of the following 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 to .....____ ☐18. Other:____

Special disease status ormatters needing attention

☐0.No ☐1.Yes(please describe)

If these diseases have not yet healed or still under treatment ,please provide medical record as care reference

Holder of Catastrophic Illness (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

High myopia:Do you currently have myopia greater than 500 degrees in either eye ? ☐0.No ☐1.Yes ☐2.Unknown

Family medical history: relative with hereditary disease ☐0.No ☐1.Yes name of disease ☐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 (*not including weekends, or days off*) ?:
   ☐①≧7 hours a day ☐②<7 hours a day ☐③ I suffer from insomnia
2. How many days did you eat breakfast during the past 7 days (*not including weekends, or days off*)?: ☐⓪Never ☐①Some days:___days ☐②Every day at (Eat before 9:00☐Yes ☐No)
3. During the 7 days,how many days did you do moderate-intensity exercise, such as sports, fitness, transportation,and recreational physical activities for at least 10minutes each time per day ? ☐⓪0 days ☐①1day ☐②2day ☐③3day ☐④4day ☐⑤5day ☐⑥6ay ☐⑦7day
4. During the past month, did you use tobacco(including cigarettes,e-cigarettes and iQOS)?: ☐①Not at all ☐②Quit ☐③Some days (☐ⓐcigarette☐ⓑe-cigarettes☐ⓒiQOS) ☐④Every day (☐ⓐ cigarette☐ⓑ e-cigarettes☐ⓒ iQOS)
5. During the past month, did you drink alcohol? ☐①Not at all ☐②Some days ☐③Every day(☐2 drinks or more ☐1 drink ☐less than 1 drink) ☐④Quit
   (*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?
   ☐Not at all ☐Some days ☐Every day ☐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?
   ☐①At least once every☐②Once in 2 days ☐③Once in 3 days ☐④Once 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 every day,apart form 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?
    ☐①None ☐②1 time ☐③2 times ☐④3 or more times
12. How often do you have a dental cheekup even if there no toothache or other oral discomfort ?
    ☐①Once every 6 months ☐②Once a year ☐③More then one year ☐④Never
13. Menstual history (women only): Do you have painful menstral periods?
    ☐①No ☐②Light pain ☐③Severe pain ☐④Unknown/Refused

Self –rated Health

1. In general, during the past month, would you say your health is ☐①Excellent ☐②Very good ☐③Good ☐④Fair ☐⑤Poor
2. In general, during the past month, would you say your mental health is ☐①Excellent ☐②Very good ☐③Good ☐④Fair ☐⑤Poor

※ Do you currently have any health concerns? Please give details: ☐0.No ☐1.Yes:____,
do you need school assistance: ☐0.No ☐1.Yes:

Health Examination Record (to be completed by medical personnel)			Date: Year_____ Month_____ Day_____	Examiner's Signature
Height:_____cm Weight:_____kg			Waistline:_____cm	
Blood Pressure:_____/_____ mmHg			Pulse rate:_____/min	
Vision: Uncorrected: Left_____ Right_____ Corrected: Left_____ Right_____				
Eyes	☐Normal	☐Color blindness ☐Other:_____		
ENT	☐Normal	☐Hearing abnormality: ☐Left ☐Right ☐Suspected otitis media (*further diagnosis required*), 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	☐Abnormally swollen ☐Othe:_____		
Spine & limbs	☐Normal	☐Scoliosis ☐Limb deformity ☐Bowlegged (Difficulty squatting) ☐Other:_____		
Skin	☐Normal	☐Ringworm ☐Scabies ☐Wart ☐Atopic dermatitis ☐Eczema ☐Other:_____		
Oral Health Screening	Untreated caries: ☐0. NO ☐1. Yes Missing tooth(been extracted due to caries):☐ 0.No ☐1.Yes Filled tooth (been filled due to caries, including crown ,inlay etc):☐0. No ☐1. Yes Gingivitis : ☐0. No ☐1. Yes Dental calculus or tartar: ☐0. No ☐1. Yes ☐Poor oral hygiene ☐Malocclusion ☐Others			
Summary	☐Normal ☐Requires a consultation with a:_____ ☐Other:_____		Stamp of hospital/clinic where examination was done	

Laboratory Tests		1st test	Result		Laboratory Tests		1st 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)					Anti-HBS			
	MCV (fl)				Other				
	Hct (%)※								

Chest X-ray	Date of X-ray	Result: ☐No obvious abnormality ☐No active lung lesion ☐R/O TB ☐TB-related Calcification ☐Abnormal thorax ☐Pleura cavity edema ☐Scoliosis ☐Cardiomegaly ☐Bronchiectasis ☐Pulmonary infiltrates ☐Solitory pulmonary nodule ☐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