NCCU Student Health Examination Form

表單編號：QP-M14-14-21
保存年限：7 年

Contact Information

Department	______________ Department ☐ Undergraduate ☐ Transferred student ☐ Master program ☐ Master continuing education program ☐ Ph. D. program	Student No.			
		Name		Date of Entry	/ (yy)/(mm)

Date of Birth	y m d	Blood Type		Sex	☐M ☐F	I.D. No.	
Permanent address				Cell phone No.			
Mailing address	☐6˚æ ˇ# ¹# ¸ ƚő˘## ☐If different from above：#						

Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.

Health Information

※Please tick of the ailments you have had (please add details for 13. to 18.)：

☐ 1. None	☐ 7. Epilepsy	☐ 13. Psychological or mental illness: ________
☐ 2. Tuberculosis (TB)	☐ 8. SLE (Lupus)	☐ 14. Cancer：________
☐ 3.Heart disease	☐ 9. Hemophilia	☐ 15. Thalassemia
☐ 4. Hepatitis	☐ 10. G6PD deficiency	☐ 16. Major surgery：________
☐ 5. Asthma	☐ 11. Arthritis	☐ 17. Allergy：________
☐ 6. Kidney disease	☐ 12. Diabetes mellitus	☐ 18. Other：________

※Do you currently have myopia greater than 500 degrees in either eye？☐No ☐Yes ☐Unknown

※Holder of Catastrophic Illness (including Rare Disease) Certificate：☐No ☐Yes-Category:________________
※Holder of Physical/Mental Disability Manual ☐No ☐Yes Category:____________
Level：☐Mild ☐Moderate ☐Severe ☐Profound

※Special disease status or matters needing attention): ☐No ☐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：☐NO ☐Yes, Name of disease:__________ ☐Unknown
Relatives of family members suffering from major hereditary disorder：________________

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

Self-rated Health

1.During the past month, would you say your health condition is ☐Excellent ☐Good ☐Average ☐Fair ☐Poor
2.During the past month, would you say your mental health condition is ☐Excellent ☐Good ☐Average ☐Fair ☐Poor
※Do you currently have any health concerns？☐No ☐Yes，Please give details:__________
※Do you need the university/college to provide any assistance：☐No ☐Yes

According to Regulations for the Implementation of Health Examinations for Students and Regulations for Governing Visiting, Residency, and Permanent Residency of Aliens, I authorize NCCU to disclose the information on the Student Health Form to the NCCU Physical and Mental Health Center and the health examination contracted hospitals for student healthcare administration.

¹ƵΕ1：________________

Student No.		Name		Department	

Health Examination Record

Date： Year Month Day

Examiner's Signature

Height：_____cm Weight：_____kg Waistline_____cm

Blood Pressure：(1) ___/___mmHg Pulse rate：_____min (2) ___/___mmHg Pulse rate：_____min

Vision： Uncorrected：Right_____ Left_____ Corrected：Right_____Left_____

Color vision	☐Normal	☐Abnormal ☐Other：_____
Hearing	☐Normal	Hearing abnormality： ☐Left ☐Right
Eyes	☐Normal	☐ Trichiasis ☐Nystagmus ☐Ptosis ☐Other_____
Head & Neck	☐Normal	☐Wry neck (torticollis) ☐Abnormal mass ☐goiter (☐mild) ☐Other：_____
ENT	☐Normal	☐Suspected otitis media , such as from a perforated ear drum ☐Swollen tonsils ☐Earwax embolism ☐Other：_____
Chest	☐Normal	☐Cardiopulmonary disease ☐Abnormal thorax ☐Other：_____
Heart	☐Normal	☐Arrhythmia☐Heart murmur☐Tachycardia☐Bradycardia☐Other：
Abdomen	☐Normal	☐Abnormal swollen ☐Other：_____
Spine & limbs	☐Normal	☐Scoliosis ☐Limb deformity ☐Bowlegged(Difficulty squatting) ☐Other：_____
Skin	☐Normal	☐Ringworm ☐Scabies ☐Wart ☐Eczema ☐Atopic dermatitis ☐Other：_____
Oral Health Screening	☐Normal	Untreated caries：☐No ☐Yes Missing tooth (been extracted due to caries)：☐No ☐Yes Filled tooth：☐No ☐Yes Gingivitis：☐No ☐Yes Dental Calculus or tartar：☐No ☐Yes ☐Poor oral hygiene ☐Malocclusion (☐Orthodontics) ☐Other：_____

Laboratory Tests		Result	Laboratory Tests		Result
Urinalysis	Protein (+) (−)		Blood lipids	Total cholesterol (mg/dL)	
	Sugar (+) (−)				
	O.B. (+) (−)		Renal function	Creatinine (mg/dL)	
	pH			UA (mg/dL)	
Blood test	Hb (g/dl)			BUN (mg/dl)	
	WBC (10^3/μL)		Liver function	SGOT(AST) (U/L)	
	RBC (10^6/μL)			SGPT(ALT) (U/L)	
	Platelet count(10^3/μL)		Hepatitis B	HBsAg	
	MCV (fl)			Anti-HBs	
	Hct (%)				

Chest X-ray	Date of X-ray ____ Year ____ Month ____ Day	Result： ☐No obvious abnormality ☐R/O TB ☐TB-related Calcification ☐Abnormal thorax ☐Pleural cavity edema ☐Scoliosis ☐Cardiomegaly ☐Bronchiectasis ☐pulmonary infiltrates ☐Solitory pulmonary nodule ☐Other:_____	Further treatment, date, and comment:
Summary	☐Normal ☐Requires a consultation with a：_____ ☐Other:		Stamp of hospital/clinic where examination was done