大專校院學生健康資料卡英文版

School Name

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

Student ID	

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 add						Cell phone No.	Attach photo here (College decides whether to collect)
Mailing add	*If different from above*:						
Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)		Cell phone No.	
						E-mail	

Health Information

Medical History

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

☐1. None ☐4. Hepatitis ☐7. Epilepsy ☐10. GPD deficiency ☐13. Psychological or mental illness:

☐2. Tuberculosis ☐5. Asthma ☐8. SLE (Lupus) ☐11. Arthritis ☐14. Cancer:

☐3. Heart disease ☐6. Kidney disease ☐9.Hemophilia ☐12.Diabetes mellitus ☐15. Thalassemia:

☐16. Major surgery:

☐17. Allergy to: …….

☐18. Other:

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

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

Special disease status or matters 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.

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 ☐① Some days, days. ☐②Every day (Eat before 9:00 ☐Yes ☐No; Eat after 9:00 ☐Yes ☐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? ☐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 (including cigarette, e-cigarettes and iQOS)? ☐①Not at all ☐② Quit ☐③ Some days（☐ⓐcigarette、☐ⓑe-cigarettes、☐ⓒiQOS） ☐④ Every 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? ☐①Not at all ☐②Some days ☐③Every day ☐④Quit
7. Do you feel depressed? ☐①Not at all ☐②Sometimes ☐③Often
8. Do you feel worried? ☐①Not at all ☐②Sometimes ☐③Often
9. During the past 7 days, how often did you defecate? ☐①At least once every day ☐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 from when doing homework or in class? ☐①less than 2 hours ☐② 2-4 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 checkup even if there's no toothache or other oral discomfort? ☐① Once every 6 months ☐② Once a year ☐③ More than one year ☐④ Never
13. Menstrual history (women only): Do you have painful menstrual periods? ☐①No ☐② Light pain ☐③ Severe 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		*Optional* ☐Waistline: cm※	
Blood Pressure: / mmHg Pulse rate: /min※			
Vision: Uncorrected:Right Left		Corrected: Right Left	
Eyes	☐Normal	☐Color blindness△ ☐Other:	
ENT	☐Normal	Hearing abnormality: ☐Left ☐Right ☐Suspected otitis media (*further diagnosisrequired*), 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 ☐Other:	
Spine & limbs	☐Normal	☐Scoliosis ☐Limb deformity ☐Bowlegged (Difficulty squatting) ☐Other:	
Genitourinary system	☐Normal ☐Not checked	☐Abnormal foreskin ☐Varicocele ☐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(AST) (U/L)			
	WBC (10^3/μL)					SGPT(ALT) (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 ☐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