

# 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.													
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.		Attach photo here									
	Mailing address	If different from above:																					
	Emergency contact (Parents or guardian)	Relationship	Name		Phone (home)		Phone (work)		Cell phone No.														
<b>Health Information</b> 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. Arthritis <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. Thalassemia <input type="checkbox"/> 9. Hemophilia <input type="checkbox"/> 15. Heart disease: <input type="checkbox"/> 4. Hepatitis <input type="checkbox"/> 10. G6PD deficiency <input type="checkbox"/> 16. Major surgery: <input type="checkbox"/> 5. Kidney disease <input type="checkbox"/> 11. Diabetes mellitus <input type="checkbox"/> 17. Allergy to: <input type="checkbox"/> 6. Asthma: <input type="checkbox"/> 12. Epilepsy: <input type="checkbox"/> 18. Other: time of the last relapse? _____              time of the last relapse? _____										Precautions for special disease condition: If the ailments listed on the left has not yet been cured or still in the treatment, please explain it in this column as a care reference.													
<input type="checkbox"/> Holder of Catastrophic Illness Certificate - Category: <input type="checkbox"/> Holder of Physical/Mental Disability Manual - Category: Level: <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Mild										Family medical history: relative with hereditary disease _____ Name of disease _____													
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"/> ② Seldom: ___ days <input type="checkbox"/> ③ Every day at (time)? _____ 3. During the past month ( <i>not including weekends, days off, or winter or summer vacation</i> ), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: <input type="checkbox"/> ① Yes <input type="checkbox"/> ② No 4. <u>During the past month, did you smoke?</u> : <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: ___ # cigarettes per day <input type="checkbox"/> ④ Quit 5. During the past month, did you drink alcohol? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: ___ # glasses per day <input type="checkbox"/> ④ Quit ( <i>Note for ③: please say how many glasses, 'one glass' means: beer 330 ml, wine 120 ml, liquor 45 ml</i> ) 6. During the past month, did you chew betel quid? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day, ___ # quids per day <input type="checkbox"/> ④ Quit 7. Do you feel worried or depressed ? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often										8. Do you regularly feel chest discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 9. Do you regularly feel stomach discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 10. Do you regularly have headaches? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 11. Menstrual history ( <i>women only</i> ): (1) Your age at first menstruation: <input type="checkbox"/> ① Haven't begun menstruation yet <input type="checkbox"/> ② Age at first period: (2) Length of menstrual cycle: <input type="checkbox"/> ① ≤ 20 days <input type="checkbox"/> ② 21-40 days <input type="checkbox"/> ③ ≥ 41 days <input type="checkbox"/> ④ irregular ( <i>differing in length by more than 7 days</i> ) (3) Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain 12. Bowel habits: 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 13. Internet use: During the past seven 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 ≤ 1 hour <input type="checkbox"/> ② 1-2 (less than) hours <input type="checkbox"/> ③ 2-4 (less than) hours <input type="checkbox"/> ④ 4-5 (less than) hours <input type="checkbox"/> ⑤ ≥ 5 hours												
	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																					
※ Do you currently have any health concerns? Please give details:																							
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.)																							

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: Left ____ Right ____ Corrected: Left ____ Right																	
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Color blindness <input type="checkbox"/> Other:															
ENT	<input type="checkbox"/> Normal	Hearing abnormality: <input type="checkbox"/> Left <input type="checkbox"/> Right <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	<input type="checkbox"/> Normal	<input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Calculus <input type="checkbox"/> Gingivitis <input type="checkbox"/> Periodontitis <input type="checkbox"/> Dental malocclusion <input type="checkbox"/> Abnormal Oral Mucosa <input type="checkbox"/> Other:															
Dentition status: C-cavity; X-missing; <input type="checkbox"/> - filled; $\psi$ - impacted tooth; Sp.- supernumerary tooth																	
Upper Right	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper left
Lower Right	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower Left
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 <sup>st</sup> test	Result		Laboratory Tests		1 <sup>st</sup> test	Result									
Urinalysis	Protein (+) (-)		Abnormal	Follow up	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 ( $10^3/\mu\text{L}$ )					SGPT (U/L)											
	RBC ( $10^6/\mu\text{L}$ )				Hepatitis B	HbsAg											
	Platelet count ( $10^3/\mu\text{L}$ )					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"/> 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																