

# TNUA Health Examination Form

										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 <i>If different from above:</i>																			
	Emergency contact (Parents or guardian)		Relationship		Name			Phone (home)		Phone (work)		Cell phone No.								

Do you want to refer your medical report in website? Yes No

[ Female only ] :I certify that I am NOT pregnant so I would accept Chest X-ray. agree      Sign:\_\_\_\_\_

Health Information	<b>Medical History</b> 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: _____										Details of particular item/s or other matters requiring attention <input type="checkbox"/> Details given in the attached file.				
	<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														
	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' references. 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. During the past month, did you smoke?: <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 (Note for ③: please say how many glasses, 'one glass' means: beer 330 ml, wine 120 ml, liquor 45 ml) 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				
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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														
	※ Do you currently have any health concerns? Please give details:														

Health Examination Record (to be completed by medical personnel)				Date: Year _____ Month _____ Day _____				Examiner's Signature											
Height: _____ cm    Weight: _____ kg				<i>Optional</i> <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; Δ- filled; ψ- 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											
			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 <sup>3</sup> /μL)					SGPT (U/L)													
	RBC (10 <sup>6</sup> /μL)				Hepatitis B	HbsAg													
	Platelet count (10 <sup>3</sup> /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"/> 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																		