中原大學 Chung Yuan Christian University
Student Health Examination Form

Student No.	

Basic Information

Enrollment Date	(mm)/(yy) /	Dept./Institute/Program				Name	
Date of Birth	(dd)/(mm)/(yy) / /	Blood Type		Gender	☐ M ☐ F	I.D. No.	
Permanent address						Cell phone	
Mail address	☐As above ☐As right:						

Emergency contact	Relationship	Name	Phone (home)	Phone (work)

Health Information

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

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

High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye?
☐0. No ☐1. Yes ☐2.Unknown

Holder of Catastrophic Illness (including 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 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: ☐0. No ☐1. Yes, Name of disease _____ ☐2. Unknown
Relatives of family members suffering from major hereditary disorder:_____ Name of disease_____

Regular 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)?
   ☐①≥7 hours a day ☐②<7 hours a day ☐③I suffer from insomnia.
2. How often did you eat breakfast in the past 7 days (not including weekends, or days off)?
   ☐⓪Never ☐①Some days:___days. ☐②Every 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? ☐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 (cigarettes, e-cigarettes, or iQOS)?
   ☐①Not at all ☐②Some days -please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice)
   ☐③Every day - please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice) ☐④I have quit
5. During the past month, did you drink alcohol? ☐①Not at all ☐②Some days
   ☐③ Every day - please tick how many: ☐ⓐ2 drinks or more ☐ⓑ1 drink ☐ⓒless than 1 drink ☐④I 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? ☐①Not at all ☐②Some days ☐③Every day ☐④ I have quit
7. Do you feel depressed? ☐⓪Not at all ☐①Sometimes ☐②Often
8. Do you feel worried? ☐⓪Not at all ☐①Sometimes ☐②Often
9. During the past 7 days, how often did you defecate?
   ☐①At least once a day ☐②Once in 2 days ☐③Once in 3 days ☐④ 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? ☐①less than 2 hours ☐②2-4 hours ☐③4 hours or more:____hours
11. How many times do you usually brush your teeth a day? ☐⓪None ☐①Once ☐②Twice ☐③3 or more times
12. How often do you have a dental checkup even if there's no toothache or other oral discomfort?
    ☐①Once every 6 months ☐②Once a year ☐③More than one year ☐④Never
13. Menstrual cycle – female students: Do you have painful menstrual periods?
    ☐①No ☐②Light pain ☐③Severe pain ☐④ Unknown/Declined to answer

Health Self–

1.During the past month, would you say your health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor
2.During the past month, would you say your mental health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor

※Do you currently have any health concerns? ☐0. No ☐1. Yes (please describe:_____)
※Do you need the university/college to provide any assistance? ☐0. No ☐1. Yes (please describe:_____)

Health Examination Record (to be completed by medical personnel)	Date: Day_____Month_____Year_____	Examiner's Signature

Height:_____cm	Weight:_____kg	Waistline:_____cm	
Blood Pressure:_____/_____mmHg	Pulse rate: _____/min		

Vision	Uncorrected: Right_____Left_____	Corrected: Right_____Left_____	
Eyes	☐ Normal	☐Color vision deficiency ☐Other:_____	
ENT	☐ Normal	Hearing abnormality: ☐Left ☐Right ☐Suspected otitis media, 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	☐Abnormal swelling ☐Other:_____	
Spine &limbs	☐ Normal	☐Scoliosis ☐Limb deformity ☐Difficulty squatting ☐Other:_____	
Skin	☐ Normal	☐Ringworm ☐Scabies ☐Wart ☐Atopic dermatitis ☐Eczema ☐Other:_____	
Oral Health Screening	☐ Normal	Untreated caries: ☐0.No ☐1.Yes Missing tooth (been extracted due to caries): ☐0.No ☐1.Yes Filled tooth : ☐0. No ☐1. Yes Gingivitis: ☐0. No ☐1. Yes Dental calculus or tartar: ☐0.No ☐1.Yes ☐Poor oral hygiene ☐Malocclusion ☐Other:_____	

Summary	☐ Normal ☐ Requires a consultation with : ☐ 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 (+) (−)				Renal function	Creatinine (mg/dL)			
	Sugar (+) (−)					UA (mg/dL)			
	O.B. (+) (−)				Liver function	SGOT (AST)（U/L）			
	pH					SGPT (ALT)（U/L）			
Blood test	Hb (g/dL)				Blood lipids	Total cholesterol (mg/dL)			
	WBC (10^3/μL)								
	RBC (10^6/μL)				Other				
	Platelet count(10^3/μL)								
	MCV (fl)								
	HcT (%)								

Chest X-ray	Date of X-ray	Result:			Further treatment, date, and comment:
		☐No obvious abnormality	☐R/O TB	☐TB-related calcification	
		☐Abnormal thorax	☐Pleural cavity edema	☐Scoliosis	
		☐Cardiomegaly	☐Bronchiectasis	☐Pulmonary infiltrates	
		☐Solitary pulmonary nodule	☐Other:_____		

Other tests	Item	Date	Checked by	Result	Follow-up referral and notes:

Summary	Summary of health examination results, for follow-up or treatment, and case management outline