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	□M □F	I.D. No.	
Permanent address						Cell phone No.	Attach photo here
Mailing address	*If different from above*:					E-mail	
Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.		

Health Information

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

□1. None	□7. Epilepsy	□13. Psychological or mental illness:
□2. Tuberculosis	□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 to:
□6. Kidney disease	□12. Diabetes mellitus	□18. Other:

Special disease status or matters needing attention: □0. No □1. Yes (please describe):

If the ailments listed on the left has not yet healed or still under treatment, please provide medical record as care reference

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

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

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 □①Some 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 □②2-4 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? □①Once every 6 months□②Once a year □③More than one year □④Never
13. Menstrual history (*women only*): Do you have painful menstrual periods? □①No □② Light pain □③Severe pain□④Unknown/Refused

Self – rated Health

1. In general, during the past month, would you say your health is □①Excellent □②Very good □③Good □④Fair□④Poor
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:

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.)

For office use only.

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: □Right □Left □Suspected otitis media (*further diagnosis required*), 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	□Normal	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 (U/L)			
	WBC (10^3/μL)					SGPT (U/L)			
	RBC (10^6/μL)				Hepatitis B	HbsAg△			
	Platelet count (10^3/μL)					HbsAb△			
	MCV (fl)				Other	Glucose(AC)			
	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

△：The item can be examined as needed under the Implementation Regulations Regarding Students' Health Screening

※：Optional item