

長榮大學學生健康資料卡 CJC Student Health Form(自填)

Student ID											
	I.D. No./ARC No										
Name					Date of Birth		_____yy_____mm_____dd				
Dept./Class			<input type="checkbox"/> Male	<input type="checkbox"/> Femaie	Cellphone No.						
Address											
Emergency contact	Relationship		Name		(home)		Cellphone No.				
Personal Medical History	Personal Health History : Please check if you have ever had the medical historyof ?										
	<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"/> 14Cancer: : _____				
	<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 medicine/food : ____					
<input type="checkbox"/> 6.Nephralgia			<input type="checkbox"/> 12.Diabetes mellitus			<input type="checkbox"/> 18.Other : ____					
High myopia: Do you currently have myopia greater than 500 degrees in either eye ? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown											
Have major illness certificate? Type: _____											
Have physical disability handbook? Level: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Extremely severe											
Family medical history: Which, if any, of your family members have hereditary medical conditions/illness_____											
Conditions/illness_____											
Personal Health Life History	※ Choose the most appropriate answer applicable to you in the past one year ?										
	1. How many hours do you sleep a day during the past 7 days (not including weekends, or days off)? <input type="checkbox"/> 7 hours or more <input type="checkbox"/> less than 7 hours <input type="checkbox"/> Insomnia										
	2. How often did you eat breakfast in the past 7 days (not including weekends, or days off)? <input type="checkbox"/> Never <input type="checkbox"/> Some days: __days <input type="checkbox"/> Everyday(Eat: before 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> No; after 9:00 <input type="checkbox"/> Yes <input type="checkbox"/> 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 whileperforming the exercise), such as sports, fitness, commuting, and recreational physical activities for at least 10 minutes each time per day? <input type="checkbox"/> 0 day <input type="checkbox"/> 1 day <input type="checkbox"/> 2 days <input type="checkbox"/> 3 days <input type="checkbox"/> 4 days <input type="checkbox"/> 5 days <input type="checkbox"/> 6 days <input type="checkbox"/> 7 days										
	4. The past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? <input type="checkbox"/> Never <input type="checkbox"/> Some days-please tick : <input type="checkbox"/> cigarettes <input type="checkbox"/> e-cigarettes <input type="checkbox"/> iQOS (multiple choice) <input type="checkbox"/> Every day-please tick: <input type="checkbox"/> cigarettes <input type="checkbox"/> e-cigarettes <input type="checkbox"/> iQOS (multiple choice) <input type="checkbox"/> Quit										
	5. The past month, do you drink alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Some days <input type="checkbox"/> Every day - please tick how many(<input type="checkbox"/> 2 drinks or more <input type="checkbox"/> 1 drink <input type="checkbox"/> less than 1 drink) <input type="checkbox"/> I have quit(Note: 1 ‘drink’ means: 330 ml of beer, 120ml of wine, 45 ml of spirits)										
	6. During the past month, did you chew betel quid? <input type="checkbox"/> No <input type="checkbox"/> Often <input type="checkbox"/> Every day <input type="checkbox"/> Quit										
	7. Do you feel depressed? <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Often										
	8. Do you feel anxious? <input type="checkbox"/> Never <input type="checkbox"/> Seldom <input type="checkbox"/> Often										
	9. Bowel habits: the past 7 days, how often did you defecate? <input type="checkbox"/> At least 1 time a day 2 days <input type="checkbox"/> 3 days <input type="checkbox"/> over 4 days										
	10. Internet using habit: the past 7 days (not including weekends, or days off), exclude daily studying needs, how many hours had you surfed on the Internet? <input type="checkbox"/> Less than 2 hours <input type="checkbox"/> About 2-4 hours <input type="checkbox"/> About 4 hours or more hours per day,_____										
	11. How many times do you usually brush your teeth a day? <input type="checkbox"/> No <input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> 3 or more times										
	12. How often do you have a dental checkup even if there’s no toothache or other oral discomfort? <input type="checkbox"/> Once every 6 months <input type="checkbox"/> Once a year <input type="checkbox"/> More than one year <input type="checkbox"/> Never										
13. Menstrual cycle- <i>female students only</i> : Do you suffer from menstrual cramps? <input type="checkbox"/> No <input type="checkbox"/> Mild pain <input type="checkbox"/> Severe pain											
Self Assessment	1.How do you feel about your physical health condition ? <input type="checkbox"/> Very good <input type="checkbox"/> Fairly good <input type="checkbox"/> Average <input type="checkbox"/> Worse <input type="checkbox"/> Very bad										
	2. How do you feel about your mental health condition ? <input type="checkbox"/> Very good <input type="checkbox"/> Fairly good <input type="checkbox"/> Average <input type="checkbox"/> Worse <input type="checkbox"/> Very bad										
	※Do you currently have any health concerns? <input type="checkbox"/> No <input type="checkbox"/> Yes, do you need school assistance: <input type="checkbox"/> No <input type="checkbox"/> Yes										

General exam		Date: _____ Year _____ Month _____ Day			検査人員簽章	
Height :	cm	Weight :	kg	※Waistline :	cm	
		※Pulse :		beats/min		
Blood Pressure :		mmHg				
Vision	Color Blindness : <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal△ <input type="checkbox"/> Other : _____					
	Naked Eye : Left _____ Right _____					
	Corrected : Left _____ Right _____					
ENT	<input type="checkbox"/> Normal Hearing abnormality : <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Suspected otitis media <input type="checkbox"/> Perforated eardrum△ <input type="checkbox"/> Swollen tonsilso△ <input type="checkbox"/> Earwax embolismo△ <input type="checkbox"/> Other : _____					
Head & Neck	<input type="checkbox"/> Normal <input type="checkbox"/> 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"/> Heart murmur <input type="checkbox"/> Cardiac arrhythmia <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"/> Difficulty squatting <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 Untreated caries : <input type="checkbox"/> No <input type="checkbox"/> Yes Missing tooth (been extracted due to caries) : <input type="checkbox"/> No <input type="checkbox"/> Yes Filled tooth : <input type="checkbox"/> No <input type="checkbox"/> Yes Gingivitis※ : <input type="checkbox"/> No <input type="checkbox"/> Yes Dental calculus or tartar※ : <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Malocclusion <input type="checkbox"/> Other : _____					
Laboratory Tests		Result		Laboratory Tests	Result	
		Test value	Abnormal		Test value	Abnormal
Urinalysis	Protein			Serum biochemistry	GOT	U/L
	Sugar				GPT	U/L
	O.B.				BUN	mg/dl
	pH				Creatinine	mg/dl
Complete Blood Count	WBC	10 ³ /μL			Uric Acid	mg/dl
	RBC	10 ³ /μL			Total cholesterol	mg/dl
	Hb	g/dl			Triglycerides☆	mg/dl
	Hct※	%			HDL☆	mg/dl
	MCV	fl			LDL☆	mg/dl
	Platelet	10 ³ /μL			Further treatment, date, and comment:	
Sugar☆	AC	mg/dL				
Hepatitis Exa.	HBsAg△					
	Anit-HBs△					
ChestX-ray	<input type="checkbox"/> Normal <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> R/O TB <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Lung nodules <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Lung infiltration <input type="checkbox"/> Other					
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					
Overall suggestions					Stamp of hospital/clinic where examination was done	

△: Items to be handled as needed in the Implementation Measures for Student Health Check

※: School optional items

☆: School Co-opted Proj

