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| **淡江大學 學生健康資料卡( TKU Student Health Examination Form)**□大學部日間 □進學班 □轉學生□復學生 □外藉生、交換生□僑生、陸生 □碩士 □博士 | Student No. |  |
| BasicInformation | 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 | Attach photo (if the university / college wants a photo) |
| Mail address | □As above  |  |
| Emergency contact | Relationship | Name | Phone (home) | Phone (work) |  |
|  |  |  |  | Student’s E-mail |
|  |  |  |  |  |
| HealthInformation | Please tick of the ailments you have had (please add details for 13. to 18.): | □ 16. Major surgery:\_\_\_\_\_\_\_\_\_\_\_□ 17. Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ 18. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| □ 1. None □ 2. Tuberculosis□ 3. Heart disease□ 4. Hepatitis□ 5. Asthma | □ 6. Kidney disease□ 7. Epilepsy □ 8. SLE (Lupus) □ 9. Hemophilia□10. G6PD deficiency |  □ 11. Arthritis□ 12. Diabetes mellitus□ 13. Psychological or mental illness:\_\_\_\_\_□ 14. Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_□ 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)?□➀≥7 hours a day □➁<7 hours a day □➂I suffer from insomnia.
2. How often did you eat breakfast in the past 7 days *(not including weekends, or days off*)? □🄋Never □➀Some days: days. □➁Every 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? □🄋0 days □➀1 day □➁2 days □➂3 days □④4 days □⑤5 days □⑥6 days □➆7 days
4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? □➀Not at all

□➁Some days -please tick: □ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice)□➂Every day - please tick: □ⓐcigarettes □ⓑe-cigarettes □ⓒiQOS (multiple choice) □④I have quit1. During the past month, did you drink alcohol? □➀Not at all □➁Some days

□➂ 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)1. During the past month, did you chew betel nut? □➀Not at all □➁Some days □➂Every day □④ I have quit
2. Do you feel depressed? □🄋Not at all □➀Sometimes □➁Often
3. Do you feel worried? □🄋Not at all □➀Sometimes □➁Often
4. During the past 7 days, how often did you defecate? □➀At least once a day □➁Once in 2 days □➂Once in 3 days □④ Once in 4 or more days
5. 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? □➀less than 2 hours □➁2-4 hours □➂4 hours or more: hours
6. How many times do you usually brush your teeth a day? □🄋None □➀Once □➁Twice □➂3 or more times
7. How often do you have a dental checkup even if there’s no toothache or other oral discomfort? □➀Once every 6 months □➁Once a year □➂More than one year □④Never
8. Menstrual cycle – *female students*: Do you have painful menstrual periods? □➀No □➁Light pain □➂Severe pain □④ Unknown/Declined to answer
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| HealthSelf –assessment  | 1. During the past month, would you say your health condition is □➀Excellent □➁Good □➂Average □④Fair □⑤Poor
2. During the past month, would you say your mental health condition is □➀Excellent □➁Good □➂Average □④Fair □⑤Poor
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| * Do you currently have any health concerns? □0. No □1. Yes
* Do you need the university/college to provide any assistance? □0. No □1. Yes
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| 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:  |
| Urogenital system △ | □□  | NormalNot checked | □Abnormal foreskin □Varicocele □Other:  |  |
| Skin | □  | Normal | □Ringworm □Scabies □Wart □Atopic dermatitis □Eczema □Other:  |
| Oral Health Screening | □ | Normal | Untreated caries: □0.No □1.YesMissing tooth (been extracted due to caries): □0.No □1.YesFilled tooth : □0. No □1. YesGingivitis※: □0. No □1. YesDental 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 (＋) (－) |  |  |  | Bloodlipids | Total cholesterol (mg/dLt) |  |  |  |
| Sugar (＋) (－) |  |  |  | Renalfunction | Creatinine (mg/dL) |  |  |  |
| O.B. (＋) (－) |  |  |  | UA (mg/dL) |  |  |
| pH |  |  |  | BUN (mg/dL) ※ |  |  |
| Bloodtest | Hb (g/dL) |  |  |  | Liverfunction | SGOT (AST)（U/L） |  |  |  |
| WBC (103/μL) |  |  |  | SGPT (ALT)（U/L） |  |  |  |
| RBC (106/μL) |  |  |  | Hepatitis B | HBsAg △ |  |  |  |
| Platelet count(103/μL) |  |  |  | Anti-HBs △ |  |  |  |
| MCV (fl） |  |  |  | Other※ |  |  |  |  |
| HcT (%) ※ |  |  |  |  |  |  |  |
| ChestX-ray | Date of X-ray | Result:□No obvious abnormality□Abnormal thorax□Cardiomegaly□Solitary pulmonary nodule | □R/O TB  □Pleural cavity edema □Bronchiectasis □Other: | □TB-related calcification□Scoliosis□Pulmonary infiltrates  | Further treatment, date, and comment: |
| Other tests | Item | Date  | Checked by | Result | Follow-up referral and notes: |
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| 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 |