

**National Taiwan Sport University**  
**Student Health Examination Form**

National Taiwan Sport University Student Health Examination Form										Student No.														
Basic Information	Date of Entry	(mm)/(yy) /		Dept./Institute/Program				Name																
	Date of Birth	(dd)/(mm)/(yy) / /		Blood Type				Gender	<input type="checkbox"/> M <input type="checkbox"/> F		I.D. No.													
	Permanent address											Cell phone		Attach photo  (if the university / college wants a photo)										
	Mail address	<input type="checkbox"/> As above																						
	Emergency contact	Relationship	Name				Phone (home)	Phone (work)																
										Student's E-mail														
Health Information	Please tick of the ailments you have had (please add details for 13. to 18.):																							
	<input type="checkbox"/> 1. None						<input type="checkbox"/> 6. Kidney disease						<input type="checkbox"/> 11. Arthritis						<input type="checkbox"/> 16. Major surgery: _____					
	<input type="checkbox"/> 2. Tuberculosis						<input type="checkbox"/> 7. Epilepsy						<input type="checkbox"/> 12. Diabetes mellitus						<input type="checkbox"/> 17. Allergy: _____					
	<input type="checkbox"/> 3. Heart disease						<input type="checkbox"/> 8. SLE (Lupus)						<input type="checkbox"/> 13. Psychological or mental illness: _____						<input type="checkbox"/> 18. Other: _____					
	<input type="checkbox"/> 4. Hepatitis						<input type="checkbox"/> 9. Hemophilia						<input type="checkbox"/> 14. Cancer: _____											
<input type="checkbox"/> 5. Asthma						<input type="checkbox"/> 10. G6PD deficiency						<input type="checkbox"/> 15. Thalassemia: _____												
High myopia: Do you currently have myopia greater than 500 degrees (near-sightedness -5.00 diopters) in either eye? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. Unknown																								
Holder of Catastrophic Illness (including Rare Disease) Certificate: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes - Category: _____																								
Holder of Physical/Mental Disability Manual <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Category: _____																								
Level: <input type="checkbox"/> 1. Mild <input type="checkbox"/> 2. Moderate <input type="checkbox"/> 3. Severe <input type="checkbox"/> 4. Profound																								
Special disease status or matters needing attention: <input type="checkbox"/> 0. No <input type="checkbox"/> 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: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes Name of disease _____ <input type="checkbox"/> 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)? <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 often did you eat breakfast in the past 7 days (not including weekends, or days off)? <input type="checkbox"/> ④ Never <input type="checkbox"/> ⑤ Some days: _____ days. <input type="checkbox"/> ⑥ Every day (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 while performing the exercise), such as sports, fitness, commuting, and recreational physical activities for at least 10 minutes each time per day? <input type="checkbox"/> ⑦ 0 days <input type="checkbox"/> ⑧ 1 day <input type="checkbox"/> ⑨ 2 days <input type="checkbox"/> ⑩ 3 days <input type="checkbox"/> ⑪ 4 days <input type="checkbox"/> ⑫ 5 days <input type="checkbox"/> ⑬ 6 days <input type="checkbox"/> ⑭ 7 days																							
	4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or IQOS)? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ②, Some days - please tick: <input type="checkbox"/> ③a cigarettes <input type="checkbox"/> ④b e-cigarettes <input type="checkbox"/> ⑤c IQOS (multiple choice) <input type="checkbox"/> ⑥f Every day - please tick: <input type="checkbox"/> ③a cigarettes <input type="checkbox"/> ④b e-cigarettes <input type="checkbox"/> ⑤c IQOS (multiple choice) <input type="checkbox"/> ⑦I have quit																							
	5. During the past month, did you drink alcohol? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day - please tick how many: <input type="checkbox"/> ④a 2 drinks or more <input type="checkbox"/> ⑤b 1 drink <input type="checkbox"/> ⑥c less than 1 drink <input type="checkbox"/> ⑦I 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? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Some days <input type="checkbox"/> ③ Every day <input type="checkbox"/> ④ I have quit																							
	7. Do you feel depressed? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often																							
	8. Do you feel worried? <input type="checkbox"/> ① Not at all <input type="checkbox"/> ② Sometimes <input type="checkbox"/> ③ Often																							
	9. During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once a 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																							
	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? <input type="checkbox"/> ① less than 2 hours <input type="checkbox"/> ② 2-4 hours <input type="checkbox"/> ③ 4 hours or more: _____ hours																							
	11. How many times do you usually brush your teeth a day? <input type="checkbox"/> ① None <input type="checkbox"/> ② Once <input type="checkbox"/> ③ Twice <input type="checkbox"/> ④ 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"/> ① Once every 6 months <input type="checkbox"/> ② Once a year <input type="checkbox"/> ③ More than one year <input type="checkbox"/> ④ Never																							
13. Menstrual cycle – female students: Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain <input type="checkbox"/> ④ Unknown/Declined to answer																								
Health Self	During the past month, would you say your health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor																							
	During the past month, would you say your mental health condition is <input type="checkbox"/> ① Excellent <input type="checkbox"/> ② Good <input type="checkbox"/> ③ Average <input type="checkbox"/> ④ Fair <input type="checkbox"/> ⑤ Poor																							
	※Do you currently have any health concerns? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes ※Do you need the university/college to provide any assistance? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes																							

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			<input type="checkbox"/> Normal <input type="checkbox"/> Requires a consultation with : <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
Urinaly- sis	Protein (+) (−)				Blood lipid	Total cholesterol (mg/dl)			
	Ketone (+) (−)					TG			
	Sugar (+) (−)					HDL			
	O.B. (+) (−)					LDL			
	pH					Renal function	Creatinine (mg/dl)		
Blood test	Hb (g/dl)				UA (mg/dl)				
	WBC (10 <sup>3</sup> /μL)				BUN (mg/dl)				
	RBC (10 <sup>6</sup> /μL)				Liver function	SGOT (U/L)			
	Platelet count (10 <sup>3</sup> /μL)					SGPT (U/L)			
	MCV (fl )				Hepatitis B	HBsAg			
	Hct (%)					Anit-HBs			
	AC suger(mg/dl)					HbeAg			
EKG									
Chest X-ray	Date of X-ray	Result: <input type="checkbox"/> No obvious abnormality    □R/O TB    □TB-related Calcification <input type="checkbox"/> Abnormal thorax    □Pleural cavity edema    □Scoliosis    □Cardiomegaly <input type="checkbox"/> Bronchiectasis    _____    □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								