☐Day School
☐Evening School
☐Weekend School
☐Transfer Student

Self Filling

Jinwen University of Science and Technology
Student Health Record

Student ID No.	

Contact Information

Date of Entry	(yy)/(mm) /	Date of Birth	(yy)/(mm)/(dd) / /	Blood Type		Name	
Dept./Institute /Class		Sex	☐ M ☐F	I.D. or Passport no.			
		E-mail					

Nationality/ Status: ☐1. Aboriginal ☐2.Overseas Chinese student ☐3.Foreign student ☐4. The Hong Kong and Macau student ☐5.Mainland Chinese student

Permanent address		Student Cell phone No.
Mailing address	*If different from above*:	

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

☐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. G6PDdeficiency ☐16. Major surgery:____
☐5. Asthma ☐11. Arthritis ☐17. Allergy to:____
☐6. Kidney disease ☐12. Diabetes mellitus ☐18. Other:____

Details of particular items or other matters requiring attention
☐Completely recovered
☐Under treatment
☐Routine follow-up
☐Have not yet recovered and undated follow-up

☐Holder of Catastrophic Illness Certificate-Category:____
☐Holder of Physical/Mental Disability Manual-Category:____ Level: ☐Very serious ☐Serious ☐Moderate ☐Mild

If you 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' references.

Family medical history：relative with hereditary disease____ Name of disease____

Apart from report in paper, available to check on web-site ? ☐Agree ☐Disagree
Female only :I identified no pregnancy ☐Agree ☐Disagree ,Willing to accept X-ray related physical examination, please confirmed and signature :

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*) ?: ☐①Never
   ☐②Seldom:____days ☐③Every day at(time)?____
3. During the past month(*not including weekends, days off, or winter or summer vacation*) , have you exercised three times a week ,for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?:☐①Yes ☐②No
4. During the past month, did you smoke?: ☐① No ☐② Often
   ☐③Every day:____#cigarettes per day ☐④Quit
5. During the past month, did you drink alcohol?: ☐① No ☐② Often ☐③Every day:____#glasses per day ☐④Quit
   (*Note for*: *please say how many glasses, one glass means: beer 330 ml, wine 120 ml, liquor 45 ml*)
6. During the past month, did you chew betel quid ?
   ☐② Often ☐③Every day:____#quids per day ☐④Quit
7. Do you feel worried or depressed ?
   ☐①No ☐②Seldom ☐③Often
8. Do you regularly feel chest discomfort ?
   ☐①No ☐②Seldom ☐③Often
9. Do you regularly feel stomach discomfort ?
   ☐①No ☐②Seldom ☐③Often
10. Do you regularly feel headaches ?
   ☐①No ☐②Seldom ☐③Often
11. Menstrual history (*for ladies only*):
   (1) Your age at first menstruation:☐①Haven't begun Menstruation yet ☐②Aga at first period:____
   (2) Length of menstrual cycle:☐①≦20 days
   ☐②21-40 days ☐③≧41 days
   ☐④irregular (*differing in length by more than 7days*)
   (3) Do you have painful menstrual periods?☐①No
   ☐②Light pain ☐③Severe pain
12. Bowel habits: During the past 7 days, how often did you defecate ? ☐①At least once every day ☐②Oncien2 days ☐③Once in 3 days ☐④Once in 4 or more days
13. Internet use: During the past seven days(*not including weekends, or days off*), how many hours did you use the interent every day , apart from when doing homework or in class?☐①≦1 hour ☐②1-2 (less than)hours
   ☐③2-4 (less than)hours ☐④4-5 (less than)hours
   ☐④≧5hours
14. How many days of week do you eat to reach 5 kinds of fresh food (2 kinds of fruits and 3 kinds of vegetables) per day ?:☐≦**1** day ☐2-3 days ☐4-5 days ☐6-7 days
15. When you usually go to bed in the night per day**:**
   ☐ PM 10:00-12:00 ☐AM 00:01-02:00 ☐ Over 02:01
16. How many days of week do you eat breakfast every morning **:**☐≦1 day ☐2-3 days ☐4-5 days ☐6-7 days
17. How many days of week do you exercise as least 30 mins per day :☐≦1 day ☐2-3 days ☐4-5 days ☐6-7 days

Health self-rated

1. In general ,during the past month, would you say your health is ☐①Excellent ☐②Very good ☐③Good ☐④Fair☐⑤Poor
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:

Recorded by physician

Item Date	Year______ Month______ Day______							
General examination	Build	Height ： cm		Weight： kg		Waist circumference： cm		BMI： kg/m²
	Blood pressure	______/______ mmHg			Pulse rate	______/min		
	Visual acuity	uncorrected	R： L：		Corrected	R： L：		
	Color Differentiation		☐ Normal ☐ Abnormal					
	Hearing		R：☐ Normal ☐ Abnormal		L：☐ Normal ☐Abnormal			

Eyes	☐Normal	☐ Strabismus ☐ Trichiasis ☐ Nystagmus ☐ Ptosis ☐ Other:________
ENT	☐Normal	☐ 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:________
Heart	☐Normal	☐ Arrythmia ☐ Heart Murmur
Abdomen	☐Normal	☐ Abnormally swollen ☐ Other:________
Spine & limbs	☐Normal	☐ Scoliosis ☐ Limb deformity ☐ Bowlegged(Difficulty squatting) ☐ Other:________
Skin	☐Normal	☐ Ringworm ☐ Scabies ☐ Wart ☐ Atopic dermatitis ☐ Eczema ☐ Other:________
Oral	☐Normal	☐ Poor oral hygiene ☐ Calculus ☐ Gingivitis ☐ Periodontitis ☐ Dental malocclusion ☐ Abnormal Oral Mucosa ☐ Other:________
Oral cavity	Dentition status: C=cavity ; X=missing ; Δ=filled ; /=impacted tooth ; Sp.=supernumerary tooth	

																		Signed by: (Doctor signature)
Upper Right	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	Upper Left	
Lower Right	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	Lower Left	

Laboratory Tests		Blood Tests		Blood Lipid	Renal function		Liver function	Hepatitis B
Protein		WBC:	MCV:	Triglyceride：	Creatinine:		SGOT:	HBsAg:
Sugar		RBC:	MCH:	Cholesterol:	UA:		SGPT:	HBsAb:
O.B.		Hb:	MCHC:	high-density lipoprotein：	BUN:			HBeAg:
PH		Ht:	Platelet count:		**BMI**		**Blood number**	
Blood glucose	AC sugar： ☐ an empty stomach ☐ on a full stomach ______ hours							
Chest X-ray	Result: ☐ No obvious abnormality ☐ R/O TB ☐ TB-related Calcification ☐ Abnormal thorax ☐ Pleura cavity edema ☐ Scoliosis ☐ Cardiomegaly ☐ Bronchiectasis ☐ Other:________							

Summary	Summary of health examination results ,for follow-up or treatment ,and case management outline	**Signed by:** (Doctor signature)	