Fooyin University Student Health Examination Form
Ministry of Education, Taiwan, R.O.C. (Revised Version)

Student No.	

Basic Information

Date of Entry	(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		

Health Information

Please tick of the ailments you have had (please add details for 13. to 18.):

☐1. None ☐6. Kidney disease ☐11. Arthritis ☐16. Major surgery: ____
☐2. Tuberculosis ☐7. Epilepsy ☐12. Diabetes mellitus ☐17. Allergy:_____
☐3. Heart disease ☐8. SLE (Lupus) ☐13.Psychological or mental illness:_____ ☐18.Other:
☐4. Hepatitis ☐9. Hemophilia ☐14. Cancer:
☐5. Asthma ☐10.G6PD deficiency ☐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)?
☐①≥7 hours a day ☐②<7 hours a day☐③I suffer from insomnia
2. How often did you eat breakfast in the past 7 days *(not including weekends, or days off)*?
□€ Never □• Some days:_days. □, Every 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?☐€ 0 days ☐• 1 day ☐, 2 days ☐ƒ 3 days ☐4 days ☐5 days ☐6 days ☐‡ 7 days
4. During the past month, did you use tobacco (cigarettes, e-cigarettes, or iQOS)? □• Not at all
☐, Some days -please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice)
☐ƒ Every day - please tick: ☐ⓐcigarettes ☐ⓑe-cigarettes ☐ⓒiQOS (multiple choice) ☐④I have quit
5. During the past month, did you drink alcohol? ☐①Not at all ☐②Some days
☐③Every 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)
6. During the past month, did you chew betel nut? ☐①Not at all ☐②Some days ☐③Every day ☐④I have quit
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 a 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 everyday, 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 ☐②Once ☐③Twice ☐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 cycle – *female students*: Do you have painful menstrual periods?
☐①No ☐②Light pain ☐③Severe pain ☐④Unknown/Declined to answer

Health Self

During the past month, would you say your health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor
During the past month, would you say your mental health condition is ☐①Excellent ☐②Good ☐③Average ☐④Fair ☐⑤Poor

	※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

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 △	□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 : □0. No □1. Yes Gingivitis※: □0. No □1. Yes Dental 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
Urinaly-sis	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)					Anit-HBs △			
	MCV (fl)				Other※				
	Hct (%)※								

Chest X-ray	Date of X-ray	Result: □No obvious abnormality □R/O TB □TB-related Calcification □Abnormal thorax □Pleural cavity edema □Scoliosis □Cardiomegaly □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

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

※：Optional item