

University/College Name Chang Gung University Student Health Examination Form										Student No.	
Ministry of Education, Taiwan, R.O.C. (Revised Version)											
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	
	Mail address	☐ As above									
	Student's E-mail									Attach photo (if the university / college wants a photo)	
	Emergency contact	Relationship	Name			Phone (home)	Phone (work)				
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:				
Health Information	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 Life-style	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 ☐ ③ I 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 ☐ 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: ☐ ② cigarettes ☐ ⑥ e-cigarettes ☐ ③ iQOS (multiple choice) ☐ Every day - please tick: ☐ ② cigarettes ☐ ⑥ e-cigarettes ☐ ③ iQOS (multiple choice) ☐ ④ I have quit										
	5. During the past month, did you drink alcohol? ☐ ① Not at all ☐ ② Some days ☐ ③ Every day - please tick how many: ☐ ② 2 drinks or more ☐ ⑥ 1 drink ☐ ③ less than 1 drink ☐ ④ I 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? ☐ ① Not at all ☐ ② Some days ☐ ③ Every day ☐ ④ I have quit										
	7. Do you feel depressed? ☐ ① Not at all ☐ ② Sometimes ☐ ③ Often										
	8. Do you feel worried? ☐ ① Not at all ☐ ② Sometimes ☐ ③ Often										
	9. During the past 7 days, how often did you defecate? ☐ ① At least once a day ☐ ② Once in 2 days ☐ ③ Once in 3 days ☐ 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? ☐ ① less than 2 hours ☐ ② 2-4 hours ☐ ③ 4 hours or more: _____ hours										
	11. How many times do you usually brush your teeth a day? ☐ ① None ☐ ② Once ☐ ③ Twice ☐ ④ 3 or more times										
	12. How often do you have a dental checkup even if there's no toothache or other oral discomfort? ☐ ① Once every 6 months ☐ ② Once a year ☐ ③ More than one year ☐ ④ Never										
	13. Menstrual cycle – female students: Do you have painful menstrual periods? ☐ ① No ☐ ② Light pain ☐ ③ Severe pain ☐ ④ Unknown/Declined to answer										
Health Self	During the past month, would you say your health condition is ☐ ② Excellent ☐ ③ Good ☐ ④ Average ☐ ⑤ Fair ☐ ⑥ Poor										
	During the past month, would you say your mental health condition is ☐ ① Excellent ☐ ② Good ☐ ③ Average ☐ ④ Fair ☐ ⑤ Poor										
	※ 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		1 st test	Result		Laboratory Tests		1 st test	Result	
			Abnormal	Follow up				Abnormal	Follow up
Urinalysis	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							