

School Name _____ Student Health Examination Form
 Ministry of Education, Taiwan, R.O.C. (Revised Version)

Student No. _____

Contact Information	Date of Entry	(yy)/(mm) /	Dept./Institute	Class	Number	Name															
	Date of Birth	(yy)/(mm)/(dd) / /	Blood Type	Sex	<input type="checkbox"/> M <input type="checkbox"/> F	I.D. No.															
	Permanent address											Cell phone No.		Attach photo here							
	Mailing address	If different from above:																			
	Emergency contact (Parents or guardian)	Relationship	Name	Phone (home)	Phone (work)	Cell phone No.															

Health Information	Medical History	Details of particular item/s or other matters requiring attention
	Please tick any of the following ailments you have had (<i>please add details for 13. to 18.</i>):	<input type="checkbox"/> Details given in the attached file.
	<input type="checkbox"/> 1. None <input type="checkbox"/> 7. Epilepsy <input type="checkbox"/> 13. Psychological or mental illness: _____ <input type="checkbox"/> 2. Tuberculosis <input type="checkbox"/> 8. SLE (Lupus) <input type="checkbox"/> 14. Cancer: _____ <input type="checkbox"/> 3. Heart disease <input type="checkbox"/> 9. Hemophilia <input type="checkbox"/> 15. Thalassemia: _____ <input type="checkbox"/> 4. Hepatitis <input type="checkbox"/> 10. G6PD deficiency <input type="checkbox"/> 16. Major surgery: _____ <input type="checkbox"/> 5. Asthma <input type="checkbox"/> 11. Arthritis <input type="checkbox"/> 17. Allergy to: _____ <input type="checkbox"/> 6. Kidney disease <input type="checkbox"/> 12. Diabetes mellitus <input type="checkbox"/> 18. Other: _____	
	<input type="checkbox"/> Holder of Catastrophic Illness Certificate - Category: _____ <input type="checkbox"/> Holder of Physical/Mental Disability Manual - Category: _____ Level: <input type="checkbox"/> Very serious <input type="checkbox"/> Serious <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	
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' references.		
Family medical history: relative with hereditary disease _____ Name of disease _____		

Lifestyle	※ Tick the box that best describes your lifestyle: 1. How much did you sleep during the past 7 days (<i>not including weekends, or days off</i>)?: <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 many days did you eat breakfast during the past 7 days (<i>not including weekends, or days off</i>)?: <input type="checkbox"/> ① Never <input type="checkbox"/> ② Seldom: _____ days <input type="checkbox"/> ③ Every day at (time)? _____ 3. During the past month (<i>not including weekends, days off, or winter or summer vacation</i>), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: <input type="checkbox"/> ① Yes <input type="checkbox"/> ② No 4. During the past month, did you smoke?: <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # cigarettes per day <input type="checkbox"/> ④ Quit 5. During the past month, did you drink alcohol? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day: _____ # glasses per day <input type="checkbox"/> ④ Quit (Note for ③: 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? <input type="checkbox"/> ① No <input type="checkbox"/> ② Often <input type="checkbox"/> ③ Every day, _____ # quids per day <input type="checkbox"/> ④ Quit	7. Do you feel worried or depressed ? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 8. Do you regularly feel chest discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 9. Do you regularly feel stomach discomfort? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 10. Do you regularly have headaches? <input type="checkbox"/> ① No <input type="checkbox"/> ② Seldom <input type="checkbox"/> ③ Often 11. Menstrual history (<i>women only</i>): (1) Your age at first menstruation: <input type="checkbox"/> ① Haven't begun menstruation yet <input type="checkbox"/> ② Age at first period: _____ (2) Length of menstrual cycle: <input type="checkbox"/> ① ≤ 20 days <input type="checkbox"/> ② 21-40 days <input type="checkbox"/> ③ ≥ 41 days <input type="checkbox"/> ④ irregular (<i>differing in length by more than 7 days</i>) (3) Do you have painful menstrual periods? <input type="checkbox"/> ① No <input type="checkbox"/> ② Light pain <input type="checkbox"/> ③ Severe pain 12. Bowel habits: During the past 7 days, how often did you defecate? <input type="checkbox"/> ① At least once every 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 13. Internet use: During the past seven days (<i>not including weekends, or days off</i>), how many hours did you use the internet every day, apart from when doing homework or in class? <input type="checkbox"/> ① ≤ 1 hour <input type="checkbox"/> ② 1-2 (less than) hours <input type="checkbox"/> ③ 2-4 (less than) hours <input type="checkbox"/> ④ 4-5 (less than) hours <input type="checkbox"/> ⑤ ≥ 5 hours
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Self-rated Health

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
 3. How is your daily dietary intake of vegetables and fruits? under 2 vaggie & fruit 2-4 vaggie & fruit every day 5-9 vaggie & fruit every day
 4. How do you reduce your stress? eating food sleeping talk to someone others: _____
 5. In general, what are your water intake habits? never water, only soft drink more soft drink than water more water than soft drink only water
 6. How many days do you exercise over 30 minutes per week, excluding PE class? 1-2 days 3-4 days 5-6 days every day
 7. What are your most concerns about health problems (e.g., constipation): 1. _____ 2. _____ 3. _____
 8. What are your most wishes for health promotion activities (e.g., walking): 1. _____ 2. _____ 3. _____
- ※ Do you currently have any health concerns? Please give details: