College or University Name <u>**National Chung Hsing University**</u> **Student Health Information Card**
(MOE Revised Version)

Student ID No.	

Student Basic Information

Date of Enrollment	___/_____ (MM/YYYY)	Department (Institute) and Division				Name	
Date of birth	____/____/____ (MM/DD/YYYY)	Blood Type		Sex	□Male □Female	National ID Number	
Permanent Address						Mobile Number	
Mailing address	□Same as above □As shown on the right:						
Emergency Contact, Guardian or Relative	Relationship	Name	Phone (Home)	Phone (Work)	Mobile Number	Student's E-mail	

Basic Health Information

Medical history: Please tick the ailments suffered

□1. Nil	□6. Kidney disease	□11. Arthritis	□16. Major surgery: ______
□2. Tuberculosis	□7. Epilepsy	□12. Diabetes	□17. Allergy to: ______
□3. Heart disease	□8. Systemic Lupus Erythematosus (SLE)	□13. Psychological or mental illness: ______	□18. Other: ______
□4. Hepatitis	□9. Hemophilia	□14. Cancer: ______	
□5. Asthma	□10. G6PD deficiency	□15. Thalassemia: ______	

Holder of Major Illness/Injury (including Rare Disease) Certificate: □0. Nil □1. Yes, type:

Holder of disability identification or (and) certification: □0. Nil □1. Yes, type: Grade: □1. Profound □2. Severe □3. Moderate □4. Mild

Rare disease status or matters requiring attention: □0. Nil □1. Yes (please describe):

If the student is being treated for or recovering from any of the above or some other disease, please inform the medical personnel and also provide the medical records for the healthcare professionals' references.

Family medical history: □0. Nil □1. Yes, relative with hereditary disorder: __________; name of disease: _______, □2. No idea

Lifestyle

* Please tick the boxes applicable:

1. How much did you sleep in the past 7 days (not including weekends, or days off)? □① 7 hours a day □② <7 hours a day □③ Frequent insomnia
2. How often did you have breakfast in the past 7 days (not including weekends, or days off)? □① Never □② Sometimes, no. of days: ____ □③ Everyday: 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 (i.e., able to talk but not sing), such as sports, fitness, commuting, and recreational physical activities for at least 10 minutes per day? □① 0 day □② 1 day □③ 2 days □④ 3 days □⑤ 4 days □⑥5 days □⑦6 days □⑧ 7 days
4. In the past one month, did you use tobacco (including regular cigarettes, e-cigarettes, or heated cigarettes)? □① Non-smoker □② Sometimes (multiple selections allowed: □ⓐ Regular cigarettes, □ⓑ E-cigarettes, □ⓒ Heated cigarettes, etc.) □③ Smoking every day (multiple selections allowed: □ⓐ Regular cigarettes, □ⓑ E-cigarettes, □ⓒ Heated cigarettes, etc.) □④ Already quit.
5. During the past month, did you drink alcohol? □① No □② Drink frequently □③ Drinking every day, □ⓐ 2 cups or more, □ⓑ 1 cup, □ⓒ Less than 1 cup □④ Already quit. (Note: Those who select "Drinking every day" shall indicate the number of cups drunk; one cup is equivalent to 330 ml of beer, or 120 ml of wine, or 45 ml of liquor)
6. In the past one month, did you chew betel nuts? □① No □② Chewing betel nuts frequently □③ Chewing betel nuts every day, No. of betel nuts/day: ____ □④ Already quit
7. Do you feel depressed? □① No □② Sometimes □③ Often
8. Do you feel anxious? □① No □② Sometimes □③ Often
9. In the past 7 days, how often did you defecate? □① At least once a day □② Once every two days □③ Once every three days □④ Once every four days or more
10. In 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 Approximately 2-4 hours □③ Approximately 4 hours or more, no. of hours: ___
11. How many times do you usually brush your teeth a day? □⓪ 0 times □① 1 time □② 2 times □③ 3 times or more
12. How often do you have a dental checkup even if there's no toothache or other oral discomfort? □① Once every six months □② Once a year □③ More than one year □④ Never
13. Menstrual cycle (for female students only): Do you suffer cramps during menstrual periods? □① No □② Mild pain □③ Serious pain □④ No idea/decline to answer

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1. In the past one month, how would you describe your health condition? □① Excellent □② Very good □③ Good □④ Satisfactory □⑤ Not good

	2. In the past month, how would you describe your mental health condition? □① Excellent □② Very good □③ Good □④ Satisfactory □⑤ Not good
	* Do you currently have any health concerns? Please describe: □0. Nil □ 1. Yes; do you need assistance from the University: □0. No □1. Yes
★ Remarks **(Required)**	■ First-year students are required to refer to the schedule of the group health check-up for each department when they enroll. Those who are unable to attend the health check-up at the University are required to go to a hospital with a thoracic medicine department (excluding a laboratory) for a health check-up. After the check-up, please make 1-2 copies of the health report. Students shall retain one copy; students who need to attend physical education class shall submit a copy to the Office of Physical Education and Sports for teaching activities reference. Those who opt to undergo health check-ups off-campus shall submit the original report to the Health and Counseling Center (1st Floor, Hui-Sun Auditorium; 04-22840235) of the Office of Student Affairs after enrollment. ■ If any abnormalities are found in the health check-up results, please seek medical treatment as soon as possible. If you have an infectious disease such as tuberculosis, you shall only be allowed to attend classes after your condition is under control.
	■ When the Ministry of Education needs to analyze and statistically process the personal lifestyle and health examination data of first-year students in colleges and universities nationwide, if the University needs to provide the students' health examination data, please seek consent from the students' parents or the students (who are age 20 or older) and fill in the date. □Parent's signature/date: _____ □Student's signature/date:_____ □If you do not consent to provide the information, the health check-up form shall only be given to the University for statistical and monitoring purposes. Parent's or student's signature/date:

Full-body Check-up	Date of Check-up: ____/____/____ (MM/DD/YYYY) Check-up results (please check the applicable boxes)		Examiner's Signature
Height: _____cm Weight: ____kg		Waistline: _____cm	
Blood Pressure: _____/_____ mmHg		Pulse Rate: ____/min	
Vision: Bare Eyesight: Right eye _____ Left eye _____, Eyesight After Correction: Right eye _____ Left eye _____			
Eyes	□ No obvious abnormality	□ Color vision abnormality □ Other	
Ear, Nose, and Throat	□ No obvious abnormality	Hearing abnormality: □ Left ear □ Right ear □ Suspected otitis media, e.g., ruptured eardrum □ Swollen tonsils □ Cerumen impaction □ Other	
Head & Neck	□ No obvious abnormality	□ Torticollis □ Abnormal mass □ Other _____	
Chest	□ No obvious abnormality	□ Cardiopulmonary diseases □ Abnormal thorax □ Other _____	
Abdomen	□ No obvious abnormality	□ Abdominal swelling □ Other _____	
Spine & limbs	□ No obvious abnormality	□ Scoliosis □ Limb deformity □ Frog legs (difficulty in squatting) □ Other _____	
Skin	□ No obvious abnormality	□ Ringworm □ Scabies □ Wart □ Atopic dermatitis □ Eczema □ Other _____	
Oral Health	□ No obvious abnormality	Untreated caries: □0. Nil □1. Yes Missing tooth (extracted due to caries): □0. Nil □1. Yes Filled tooth: □0. Nil □1. Yes Gingivitis * □0. Nil □1. Yes Tartar *: □0. Nil □1. Yes □ Poor oral hygiene □ Malocclusion □ Other	

Summary	□ No obvious abnormality □ Abnormality found, treatment required: _____ □ Other recommendation:	Stamp of hospital/clinic where check-up is done

Laboratory Test		Preliminary Test	Test Result		Laboratory Test		Preliminary Test	Test Result	
			Notes on abnormality	Follow-up				Notes on abnormality	Follow-up
Urinalysis	Proteinuria (+) (-)				Blood Lipids	Triglyceride (mg/dl)			
	Urine sugar (+) (-)					Total cholesterol (mg/dl)			
	Occult blood (+) (-)					Low-density lipoprotein cholesterol (mg/dl)			
	pH					High-density lipoprotein cholesterol (mg/dl)			
Blood Test	Fasting blood glucose (mg/dl)				Renal Functions	Creatinine (mg/dl)			
	Hb (g/dl)					Uric acid (mg/dl)			
	White blood cells (103/μL)					Blood urea nitrogen (mg/dl) *			
	Red blood cells (106/μL)				Liver Functions	SGOT (U/L)			
	Platelet count (103/μL)					SGPT (U/L)			
	MCV (fl)				Immunology and Serology	HbsAg			
	Hct (%) *					HbsAb			

■ Fasting for at least 6-8 hours prior to check-up (small amount of plain water is allowed)

Chest X-ray	Date of Scan	Test Result: □ No obvious abnormality □ Suspected TB □ TB calcification □ Abnormal thorax □ Pleural effusion □ Scoliosis □ Cardiomegaly □ Bronchiectasis □ Pulmonary infiltrate □ Pulmonary nodule □ Other _____	Follow-up and treatment, date, and notes:

Non-Routine Check-up	Item	Date of Check-up	Checked by	Test Result	Follow-up Referral and Notes

Comprehensive Health Management Record	Summary of follow-up or treatment, and case management

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Amended in May 2022