MCU Student Health Form

☐Taipei Campus
☐Taoyuan Campus
☐Kimmen Campus

Contact Information

Student ID no.		ID no . (Passport no.)		Attach photo here
Name			☐male ☐female	
Date of birth	(yy/mm/dd)	Blood type		
Department	_____ Department ☐Undergraduate ☐Work-experience program ☐Master program ☐Master's executive class section ☐Ph. D. Program _____ Class ☐T3-year cimpletion program work experience class section			
Address				
Phone no.			Cell phone no.	
Emergency contact person	Name		Phone no.	Relationship with the person

※E-mail address: _____
Do you want to refer your medical report in website? ☐Yes ☐No Sigh : _____
Do you agree the check up result to Parents, If you age already 20 years old? ☐ agree ☐disagree
[Female only]:I certify that Iam NOT pregnant so I would accept Chest X-ray. ☐agree ☐disagree

Health Information

Medical History
Please tick any of the following ailments you have had (*please add details for 13. to 18.*):

☐1. None
☐2. Tuberculosis
☐3. Heart disease
☐4. Hepatitis
☐5. Asthma
☐6. Kidney disease
☐7. Epilepsy
☐8. SLE (Lupus)
☐9. Hemophilia
☐10. G6PD deficiency
☐11. Arthritis
☐12. Diabetes mellitus
☐13. Psychological or mental illness: ____.
☐14. Cancer: _____.
☐15. Thalassemia: _____.
☐16. Major surgery: _____.
☐17. Allergy to: _____.
☐18. Other: _____.

Details of particular item/s or other matters requiring attention
☐Details given in the attached file.

☐Holder of Catastrophic Illness Certificate - Category: _____.
☐Holder of Physical/Mental Disability Manual - Category: _____ Level: ☐Very serious ☐Serious ☐Moderate ☐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 (*not including weekends, or days off*) ?:
   ☐≧7 hours a day ☐<7 hours a day ☐ I suffer from insomnia
2. How many days did you eat breakfast during the past 7 days (*not including weekends, or days off*)?: ☐Never ☐Seldom: __days ☐Every 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?: ☐Yes ☐No
4. During the past month, did you smoke?: ☐No ☐Often ☐Every day: ____ # cigarettes per day ☐Quit
5. During the past month, did you drink alcohol? ☐No ☐Often ☐Every day: ____ # glasses per day ☐Quit
   (*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? ☐No ☐Often ☐Every day, ____ # quids per day ☐Quit
7. Do you feel worried or depressed ? ☐No ☐Seldom ☐Often
8. Do you regularly feel chest discomfort? ☐No ☐Seldom ☐Often
9. Do you regularly feel stomach discomfort? ☐No ☐Seldom ☐Often
10. Do you regularly have headaches? ☐No ☐Seldom ☐Often
11. Menstrual history (*women only*):
    (1) Your age at first menstruation: ☐Haven't begun menstruation yet ☐Age at first period:
    (2) Length of menstrual cycle: ☐≦20 days ☐21-40 days ☐≧41 days ☐irregular (*differing in length by more than 7 days*)
    (3) Do you have painful menstrual periods? ☐No ☐ Light pain ☐ Severe pain
12. Bowel habits: During the past 7 days, how often did you defecate? ☐At least once every day ☐Once in 2 days ☐Once in 3 days ☐Once 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 internet every day, apart from when doing homework or in class?
    ☐≦1 hour ☐1-2 (less than)hours ☐2-4 (less than) hours ☐4-5 (less than) hours ☐≧5 hours

Self-rated Health

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

※ Do you currently have any health concerns? Please give details:

Health Examination Record (to be completed by medical personnel)		Date: Year_____ Month_____ Day_____	Examiner's Signature
Height:_____cm Weight:_____kg		☐Waistline:_____cm BMI:_____	
Blood Pressure:_____/_____mmHg Pulse rate:_____/min			
Vision: Uncorrected: Left_____ Right_____ Corrected: Left_____ Right_____			
Color blindness	☐Normal	☐Color blindness ☐Other:_____	
Hearing inspection	☐Normal	☐abnormality ☐Left ☐Right	
Head & Neck	☐Normal	☐Wry neck (torticollis) ☐Abnormal mass ☐Other:_____	
Chest	☐Normal	☐Cardiopulmonary disease ☐Abnormal thorax ☐Other:_____	
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:_____	

Dentition status: C-cavity; X-missing; △- filled; ψ- impacted tooth; Sp.- supernumerary tooth

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

Summary	☐Normal ☐Requires a consultation with a:_____ ☐Other:_____	Stamp of hospital/clinic where examination was done

Urinalysis		Hepatitis & Liver Function		Complete Blood Count	
Protein		HBsAg		WBC :	MCHC:
Sugar		HBsAb		RBC:	MCH:
O.B		HBeAg		Hb:	Hct:
PH		SGOT		PLT:	MCV:
Lipid Exam		SGPT		Chest Radiograph	
cholesterol		Renal Function			
Blood		BUN			
		UA			
		Cr			

Physical defects and suggestions

Summary	Summary of health examination results, for follow-up or treatment, and case management outline