



Instructions of NTU Health exam for foreign staff and students

In order to understand the general health condition of coming employees and students, and to meet the regulations of National Taiwan University and our government's requirements, all new staff and students should receive a health exam by a qualified physician. The registration procedure is not complete if the new employee/student does not have her/his health exam form completed.

For native employees and students, they have to perform the health exam first then their salaries can be paid or enrollment will be completed. For foreign teachers/employees/students' convenience, you may take the health exam in your countries in recent 3 months as long as the items are included with the doctor's signature and stamp of the hospital or clinic (for certification).

Attention:

1. Please inform the doctor if you are pregnant. (You are allowed to skip the CXR exam when you are pregnant.)
2. Please avoid checking your urine in the menstruation period.
3. Fasting at least for 8 hours is indicated for laboratory tests.

國立台灣大學外籍學生健康調查表 (II) – 自行填寫部分

NTU International Students General Health Check List – Self Evaluation

◎紅框內資料請詳細填寫，有各項所指情況者，請在"□"打"√"或在"_"內填寫

(Please fill in the following information and check where indicated.)

姓名 Family Name	Given Name
身份證或護照號碼 ID or Passport No. :	國籍 Nationality :
身份別 Status : <input type="checkbox"/> 1. 學士班 Undergraduate <input type="checkbox"/> 2. 研究所 Graduate <input type="checkbox"/> 3. 交換學生 Exchange Student <input type="checkbox"/> 4. 雙學位生 Dual Degree Student	
入學時間 Starting Date : _____年 Year/ _____月 Month 學號 Student ID : ()	
系所 Department / Institute :	
生日 Date of Birth: ____年 Year/ ____月 Month / ____日 Day 性別 Sex : <input type="checkbox"/> 男 Male <input type="checkbox"/> 女 Female	
婚姻狀況 Marital Status : <input type="checkbox"/> 未婚 Single <input type="checkbox"/> 已婚 Married <input type="checkbox"/> 鰥寡 Widowed <input type="checkbox"/> 離婚 Divorced	
永久住址 Permanent Address : 郵遞區號 Postal Code ()	
電話 Tel. No. :	手機 Cell Phone No. :
電子郵件信箱 E-mail Address :	
緊急聯絡人 Emergency Contact Person : _____關係 Relation : _____	
聯絡電話 Tel. No. : _____手機 Cell Phone No. : _____	
作業經歷 Work/Study Experience	
到職 (入學) 前從事之工作 Previous job/school before coming to NTU :	
<input type="checkbox"/> 學生 Student, 學校名稱 school _____ 系/所 department _____ 就學期間 Starting/Finishing Date : ____年 year / ____月 month 至 to ____年 year / ____月 month	
<input type="checkbox"/> 非學生 Non-student, 公司名稱 Company name : _____ 工作期間 Starting/Finishing Date : ____年 year / ____月 month 至 to ____年 year / ____月 month 工作內容 Job description : _____	
<input type="checkbox"/> 物理性 Physics-related <input type="checkbox"/> 化學性 Chemistry-related <input type="checkbox"/> 生物性 Biology-related <input type="checkbox"/> 輻射 Radiation-related <input type="checkbox"/> 電腦 Computer-related	
家族病史 Family Medical History	
<input type="checkbox"/> 肺結核 TB <input type="checkbox"/> 心臟病 Heart diseases <input type="checkbox"/> B型肝炎 Hepatitis B <input type="checkbox"/> 大腸癌 Colon cancer	<input type="checkbox"/> 氣喘 Asthma <input type="checkbox"/> 腎臟病 Kidney diseases <input type="checkbox"/> C型肝炎 C Hepatitis <input type="checkbox"/> 胃癌 Stomach cancer
<input type="checkbox"/> 中風 Stroke <input type="checkbox"/> 糖尿病 Diabetes <input type="checkbox"/> 肝癌 Liver cancer <input type="checkbox"/> 肺癌 Lung cancer	<input type="checkbox"/> 貧血 Anemia <input type="checkbox"/> 高脂血症 Hyperlipidemia <input type="checkbox"/> 乳癌 Breast cancer
<input type="checkbox"/> 甲狀腺疾病 Thyroid problems <input type="checkbox"/> 攝護腺癌 Prostate cancer	<input type="checkbox"/> 高血壓 Hypertension <input type="checkbox"/> 子宮頸癌 Cervical cancer
<input type="checkbox"/> 痛風或高尿酸血症 Gout or hyperuricemia <input type="checkbox"/> 精神疾病 Psychiatric disorders	<input type="checkbox"/> 無上述疾病 None of the diseases described above
<input type="checkbox"/> 其他 Others: _____	

個人預防注射紀錄 Personal Vaccination History

您是否曾接種下列疫苗？若是，請在□打✓並註明施打時間 Have you received the following vaccine injections? If yes, please mark in the square and specify the date.

	第一劑 First dose	第二劑 Second dose	第三劑 Third dose
	日期 (年/月/日)	日期 (年/月/日)	日期 (年/月/日)
	date (yr/month/day)	date (yr/month/day)	date (yr/month/day)
<input type="checkbox"/> 白喉 Diphtheria	_____	_____	_____
<input type="checkbox"/> 百日咳 Pertussis	_____	_____	_____
<input type="checkbox"/> 破傷風 Tetanus	_____	_____	_____
<input type="checkbox"/> 麻疹 Measles	_____	_____	_____
<input type="checkbox"/> 腮腺炎 Mumps	_____	_____	_____
<input type="checkbox"/> 德國麻疹 Rubella	_____	_____	_____
<input type="checkbox"/> 小兒麻痺 Polio	_____	_____	_____
<input type="checkbox"/> A 型肝炎 Hepatitis A virus	_____	_____	_____
<input type="checkbox"/> B 型肝炎 Hepatitis B virus	_____	_____	_____
<input type="checkbox"/> 日本腦炎 Japanese Encephalitis	_____	_____	_____
<input type="checkbox"/> 卡介苗 BCG	_____	_____	_____
<input type="checkbox"/> 其他 others	_____	_____	_____

個人過去病史 Personal Medical History

- | | | |
|---|--|---|
| <input type="checkbox"/> 肺結核 TB | <input type="checkbox"/> 中風 Stroke | <input type="checkbox"/> 血友病 Hemophilia |
| <input type="checkbox"/> 氣喘 Asthma | <input type="checkbox"/> 貧血 Anemia | <input type="checkbox"/> 癲癇 Epilepsy |
| <input type="checkbox"/> 高血壓 Hypertension | <input type="checkbox"/> 糖尿病 Diabetes | <input type="checkbox"/> 心臟病 Heart diseases |
| <input type="checkbox"/> 高血脂症 Hyperlipidemia | <input type="checkbox"/> 腎臟病 Kidney diseases | <input type="checkbox"/> 消化性潰瘍 Peptic ulcer |
| <input type="checkbox"/> B 型肝炎帶原 Hepatitis B carrier | | <input type="checkbox"/> C 型肝炎 Hepatitis C |
| <input type="checkbox"/> 痛風或高尿酸血症 Gout or hyperuricemia | | <input type="checkbox"/> 甲狀腺疾病 Thyroid problems |
| <input type="checkbox"/> 精神疾病 Psychiatric disorders _____ | | |
| <input type="checkbox"/> 惡性腫瘤 Malignant neoplasm(tumor) _____ | | |
| <input type="checkbox"/> 重大手術 Major operation (年齡 Age/名稱 Reason) _____ | | |
| <input type="checkbox"/> 住院史 Hospital admission history (原因 Reason) _____ | | |
| <input type="checkbox"/> 食物過敏 Food allergy (名稱 Item name) _____ | | |
| <input type="checkbox"/> 藥物過敏 Drug allergy (名稱 Drug name) _____ | | |
| <input type="checkbox"/> 無上述疾病 None of the diseases described above | | |
| <input type="checkbox"/> 其他 Others: _____ | | |

長期服藥 Long term medication: 無 No 有 Yes : 原因 Reason: _____

服用藥物名稱 Name of the drug(s) : _____

近半年健康行爲 Health condition for the past 6 months

1.睡眠習慣 Sleeping habit :

平均每日睡眠時數 Average hours of Sleep: _____小時 hours per night.

平均每週失眠 Insomnia : _____次 times per week.

2.運動習慣 Exercise habit :

a. 規則運動 Regularly 未規則運動 Not regularly

b.平均每週運動次數 exercise : _____次 times per week in average.

每次運動 each exercise lasts for _____ 分鐘 minutes. 運動方式 Type of exercise _____。

3.飲食習慣 Eating habit :

a. 三餐規則進食 Regular meals 3 times a day 經常不吃早餐 No regular breakfast

經常不吃午餐 No regular lunch

經常不吃晚餐 No regular dinner

b.平均每天攝取 In average, you have _____碟蔬菜 portion(s) of vegetables, _____份水果 portion(s) of fruits, and _____種油炸食物 items of deep fried food on a daily basis.

4.吸菸習慣 Smoking habit :

未曾 Never 有 Yes, 平均一天 In average _____支 cigarettes per day ,

約 for _____年 years, 菸 Brand (品名 Name) _____,

已戒 Quitted 未戒 Not quitted。

5.喝酒習慣 Drinking habit:

未曾 Never 有 Yes, 平均每次 In average _____cc each time ,

平均每月 approximately _____次 times every month, 約 for _____年 years ,

已戒 Quitted 未戒 Not quitted。

6.嚼檳榔習慣 betel nut chewing habit:

未曾 Never 有 Yes, 平均一天 In average per day, 約 for _____顆 nuts。

約 for _____年 years, 已戒 Quitted 未戒 Not quitted。

7.您是否有每餐飯後刷牙的習慣 Do you brush your teeth after each meal?

a. 是 Yes 否 No b.每日共刷牙 brush teeth _____次 times per day.

8.您是否有每月量體重的習慣 Do you weigh yourself every month? 是 Yes 否 No

複診追蹤記錄 Follow-up Record

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