

Health Examination Record

Student ID No.		Name		Attach photo here							
Department											
Inspection Date	(Y)	(M)	(D)								
General Exam											
Height	cm	Weight	kg								
Blood Pressure	/ mmHg	Waist	cm								
Vision	Naked eye	R:	Corrected	R:							
		L:		L:							
Color Blindness	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____										
Hearing Test	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal R : <input type="checkbox"/> _____ L: <input type="checkbox"/> _____										
Oral Cavity	R		L								
	18 17 16 15 14 13 12 11 48 47 46 45 44 43 42 41	21 22 23 24 25 26 27 28 31 32 33 34 35 36 37 38	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 25px; height: 25px; text-align: center;">D</td> <td style="width: 25px; height: 25px; text-align: center;">M</td> <td style="width: 25px; height: 25px; text-align: center;">F</td> <td style="width: 25px; height: 25px; text-align: center;">T</td> </tr> <tr> <td style="width: 25px; height: 25px;"></td> </tr> </table>		D	M	F	T			
D	M	F	T								
C= Dental Cavities ; X= Anodontia ; /= Hinder ; △= Corrected <input type="checkbox"/> Bad Oral Hygiene <input type="checkbox"/> Dental Plaque <input type="checkbox"/> Periodontal Disease <input type="checkbox"/> Malocclusion <input type="checkbox"/> Other _____											
Bio Exam											
ENT	<input type="checkbox"/> suspected otitis media (<i>further diagnosis required</i>), such as from a perforated ear drum <input type="checkbox"/> Swollen tonsils <input type="checkbox"/> Earwax embolism <input type="checkbox"/> Other: _____										
Head&Neck	orticollish	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____									
	Abnormal Mass										
	Thyroid Gland										
Chest	Heart	<input type="checkbox"/> Heart Rate _____ / Min <input type="checkbox"/> Normal <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Cardiac Arrhythmia <input type="checkbox"/> Other _____									
	Lung	<input type="checkbox"/> Normal <input type="checkbox"/> Asthma <input type="checkbox"/> Other _____									
Abdomen	<input type="checkbox"/> Normal <input type="checkbox"/> Splenohepatomegaly <input type="checkbox"/> other _____										
Muscles/Bones/ Joints	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____										
Skin	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____										
Other	<input type="checkbox"/> Normal <input type="checkbox"/> Other _____										
Urinalysis		Hepatitis & Liver Function		Complete Blood Count							
Protein		HBsAg		WBC :	10 ³ /uL MCHC: G/dL						
Sugar		HBsAb		RBC:	10 ⁶ /uL MCH: Pg						
PH		HBeAg		Hb :	g/uL Hct: %						
O.B		SGOT	U/L	PLT:	10 ³ /uL MCV: fL						
Lipid Exam		SGPT	U/L	Physical defects and suggestions							
cholesterol	mg/dL	Renal Function									
		BUN	mg/dL								
blood		UA	mg/dL	Chest Radiograph							
		Cr	mg/dL								
Records of treatment				Doctor's Signature							