National Taipei University of Nursing and Health Sciences

MEDICAL REPORT

FOR

2023

PART 1: HEALTH DECLARATION
PART 2: MEDICAL EXAMINATION FORM

Applicant name: _____

Applying for: National Taipei University of Nursing and Health Sciences (NTUNHS)

_____(fill out program name)

INSTRUCTION：

PART 1: Personal Details and Health Declaration — to be completed by the applicant

I hereby certify that the following information is true and complete, and agree that any misrepresentation or deliberate omission of a material fact on this form may result in the withdrawal of an offer of a place or scholarship, or may result in the termination of any such offer at a future date. I hereby grant the Taiwan ICDF permission to share information contained in my Medical Examination Form with relevant authorities.

X_____

Signature Date

PART 2: Medical Examination — to be completed by certified physician

☆ National Taipei University of Nursing and Health Sciences (NTUNHS) reserves the right to require the applicant to undergo a future medical examination after he/she arrives in the Republic of China (Taiwan).

PART 1: HEALTH DECLARATION

PHOTO

Nationality: _____

Name: (*Last*) _____

(*First*) _____

(*M. Initial*)_____

Gender: *Male*☐ *Female*☐ **Date of Birth:**_____Y/_____M/_____D/_

Health History:

Have you ever suffered any of the following conditions? Please mark X in appropriate box

	Yes	*No*		*Yes*	*No*
Psychiatric illness	☐	☐	Thyroid Diseases	☐	☐
Epilepsy	☐	☐	Kidney Diseases	☐	☐
Asthma	☐	☐	Cancer	☐	☐
German Measles (Rubella)	☐	☐	HIV/AIDS	☐	☐
Tuberculosis (PTB)	☐	☐	Venereal Diseases	☐	☐
Hypertension (HPT)	☐	☐	Leukemia	☐	☐
Diabetes Mellitus (DM)	☐	☐	Hemophilia	☐	☐
Heart Diseases	☐	☐	Hepatitis	☐	☐
Malaria	☐	☐	Measles	☐	☐

Please State (if any)

Other illnesses

…….

Operation / Surgical

…….

Allergic to

…….

Family Medical History **(if any)**

Father:…… Mother: ……

Past Year Life: Please select

1. Sleep: □7~8 hours every day □Under 7~ 8 hours □Often suffer from insomnia

2. If that is basic to exercise each time for 30 minutes and 3 times every week at least, did you achieve? □No □Yes

4. Do you often feel anxious and worried? □Few or not □Sometimes □Often

5. Do you often feel the chest is stuffy? □No □Sometimes □Yes

6. Stomach-ache? □No □Sometimes □Often;. Headache? □No □Sometimes □Often

7. The menarche (girl only):

(1) The age of the menarche: _____years-old

(2) Is menstrual cycle regular? □No □Yes(Date of partition _____day)

(3) Do you ever have menstrual cramp phenomenon □No □Yes

PART 2: MEDICAL EXAMINATION

Physician must complete all questions and give additional comment where necessary. Kindly note that physician is responsible for the information, suggestions and recommendation regarding the applicant's health given in this form.
Certified original lab data need to be attached as reference.

Name of Applicant: **Date of Birth**
Y/ M/ D/

Physical Examination:

HEIGHT： _____cm WEIGHT： _____kg
BLOOD PRESSURE： ____/____mmHg PULSE RATE： _____/min

VISUAL ACUITY： R L

EYES：☐normal ☐color anomalous ☐other_____

EAR/NOSE/THROAT：☐normal ☐auditory meatus abnormal ☐cleft lip and palate ☐impending infarction ☐allergic rhinitis ☐chronic rhinitis ☐other_____

NECK：☐normal ☐wryneck ☐goiter ☐the lymphoid swelling of gland is big ☐other_____

CHEST：☐normal ☐thoracic anomaly ☐core noise ☐arrhythmias ☐other_____

CHEST X RAY：☐normal ☐advertise for like the tuberculosis ☐pleura effusion ☐thoracic abnormality ☐tuberculosis calcify ☐the spinal column side is curved up ☐cardiac hypertrophy ☐bronchiectasis ☐other_____

ABDOMEN：☐normal ☐hepatomegaly ☐splenomegaly ☐hernia ☐other_____

SPINAL COLUMN ARMS AND LEGS：☐normal ☐scoliosis ☐frog limb ☐articulation deformity ☐edema ☐other_____

SKIN：☐normal ☐wart ☐purple plague ☐scabies ☐a dermatitis ☐other_____

MOUTH CAVITY：☐normal ☐oral hygiene is poor ☐calculus ☐gingivitis ☐milk tooth ☐other_____

Urine Test:

NAD ☐ WBC ☐ RBC ☐ PROTEIN ☐ CLUCOSE ☐

Hepatitis B Test:

POSITIVE ☐ NEGATIVE ☐

Is the applicant now under treatment for any physical or emotional condition?

……

Do you have any recommendations for the health care of this applicant?

……

By history and physical examination, is this applicant a carrier of any communicable disease?

……

CERTIFICATION BY THE MEDICAL OFFICER:

I certify that I have examined the above applicant and in my opinion:

☐ The applicant is medically fit to undertake a program in Taiwan

☐ The applicant suffers mental or physical defects and is NOT in good health

Name of physician, Title **:**……

Name of Hospital / Clinic **:**……

Address **:**……

……

……

Not valid if without the hospital or clinic's seal