
National Taipei University of Nursing and Health Sciences



MEDICAL REPORT

FOR

2018

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

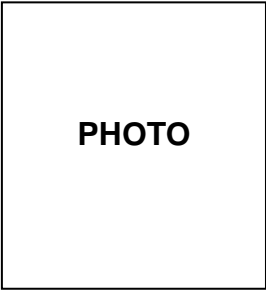
Signature

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



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

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (PTB)	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (HPT)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus (DM)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
			German Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

***Please attach your full Chest X-ray Report.**

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