

Asia University

Health Examination Record Form (Written by health examination unit)

Health Examination Record		Date: Year/ Month/ Day															
Height : _____ cm	Weight: _____ kg	Waistline: _____ cm															
Blood Pressure : _____ / _____ mmHg		Pulse rate : _____ /min															
Vision : Uncorrected: Left _____ Right _____		Corrected: Left _____ Right _____															
Eyes	<input type="checkbox"/> Normal	<input type="checkbox"/> Color blindness <input type="checkbox"/> Other: _____															
ENT	<input type="checkbox"/> Normal	Hearing abnormality: <input type="checkbox"/> Left <input type="checkbox"/> Right <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	<input type="checkbox"/> Normal	<input type="checkbox"/> Wry neck (torticollis) <input type="checkbox"/> Abnormal mass <input type="checkbox"/> Other: _____															
Chest	<input type="checkbox"/> Normal	<input type="checkbox"/> Cardiopulmonary disease <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Other: _____															
Abdomen	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormally swollen <input type="checkbox"/> Other: _____															
Spine & limbs	<input type="checkbox"/> Normal	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Limb deformity <input type="checkbox"/> Bowlegged (Difficulty squatting) <input type="checkbox"/> Other: _____															
Skin	<input type="checkbox"/> Normal	<input type="checkbox"/> Ringworm <input type="checkbox"/> Scabies <input type="checkbox"/> Wart <input type="checkbox"/> Atopic dermatitis <input type="checkbox"/> Eczema <input type="checkbox"/> Other: _____															
Oral	<input type="checkbox"/> Normal	<input type="checkbox"/> Poor oral hygiene <input type="checkbox"/> Calculus <input type="checkbox"/> Gingivitis <input type="checkbox"/> Periodontitis <input type="checkbox"/> Dental malocclusion <input type="checkbox"/> Abnormal Oral Mucosa <input type="checkbox"/> Other: _____															
Dentition status: C-cavity; X-missing; Δ- 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
Laboratory Tests		Result	Laboratory Tests		Result												
Blood Tests	Hb (g/dl)		Blood lipid	Total Cholesterol (mg/dl)													
	WBC (10 ³ /μL)			Renal Function	BUN (mg/dl)												
	RBC (10 ⁶ /μL)				UA (mg/dl)												
	Platelets (10 ³ /μL)				Cr (mg/dl)												
	MCV (fl)																
Hepatitis B	HBsAg		Liver Function	SGOT (U/L)													
	HBsAb			SGPT (U/L)													
Urinalysis	Protein (+)(-)		Urinalysis	Occult blood (+)(-)													
	Glucose (+)(-)			pH													
Chest X-ray	Result: <input type="checkbox"/> No obvious abnormality <input type="checkbox"/> R/O TB <input type="checkbox"/> TB-related Calcification <input type="checkbox"/> Abnormal thorax <input type="checkbox"/> Pleura cavity edema <input type="checkbox"/> Scoliosis <input type="checkbox"/> Cardiomegaly <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Other: _____																
Summary & Suggestion	<input type="checkbox"/> Normal		Physician's Signature	Stamp of hospital where examination was done													
	<input type="checkbox"/> Requires a consultation with a: _____																
	<input type="checkbox"/> Other: _____																