

※生理期 是 否

國立高雄科技大學 (建工 燕巢 第一 楠梓 旗津)

學生健康資料卡

學號
Student
No.

學生基本資料	入學日期 Date of Entry	年 月	就讀系所、班(組)別 Dept./Institute/Class				姓名 Name			
	出生日期 Date of Birth	年 月 日	血型 Blood Type	性別 Sex	<input type="checkbox"/> 男(M) <input type="checkbox"/> 女(F)	身分證字號 I.D. No				
	戶籍地址 Permanent address					學生本人行動電話 Cell phone No.(必填)				
	現居地址 Mailing address	<input type="checkbox"/> 同上 <input type="checkbox"/> 如右：								
緊急聯絡人、 監護人或附近 親友 Emergency contact	關係 Relationship	姓名 Name		電話(家) Phone (home)	電話(公) Phone (work)	行動電話 Cell phone No.				
健康基本資料	個人疾病史 Medical History: 勾選本人曾患過的疾病									
	<input type="checkbox"/> 1. 無 None <input type="checkbox"/> 7. 癲癇 Epilepsy(2年內曾發作) <input type="checkbox"/> 13. 心理或精神疾病 Mental illness: _____ <input type="checkbox"/> 2. Tuberculosis <input type="checkbox"/> 8. 紅斑性狼瘡 SLE(Lupus) <input type="checkbox"/> 14. 癌症 Cancer: _____ <input type="checkbox"/> 3. 心臟病 Heart disease <input type="checkbox"/> 9. 血友病 Hemophilia <input type="checkbox"/> 15. 海洋性貧血 Thalassemia: _____ <input type="checkbox"/> 4. 肝炎 Hepatitis <input type="checkbox"/> 10. 蠶豆症 G6PD deficiency <input type="checkbox"/> 16. 重大手術名稱 Major surgery: _____ <input type="checkbox"/> 5. 氣喘 Asthma(3年內曾發作) <input type="checkbox"/> 11. 關節炎 Arthritis <input type="checkbox"/> 17. 過敏物質名稱 Allergy to: _____ <input type="checkbox"/> 6. 腎臟病 Kidney disease <input type="checkbox"/> 12. 糖尿病 Diabetes Mellitus <input type="checkbox"/> 18. 其他 Other: _____									
	<input type="checkbox"/> 領有重大傷病證明卡, 類別(Holder of Catastrophic Illness Certificate - Category) _____ <input type="checkbox"/> 領有身心障礙手冊, 類別(Holder of Physical/Mental Disability Manual - Category) _____ 等級(Level): <input type="checkbox"/> 極重度(very serious) <input type="checkbox"/> 重度(serious) <input type="checkbox"/> 中度(moderate) <input type="checkbox"/> 輕度(mild)									
	若有上述特殊疾病尚未痊癒或仍在治療中, 請主動告知並提供就診病歷摘要, 以作為照護參考 If you are being treated for or recovering from any of the above or some other disease, please inform the medical personnel and also provide your medical records for the healthcare professionals' references.									
家族疾病史 Family medical history: 患有重大遺傳性疾病之家屬稱謂 (relative with hereditary disease): _____, 疾病名稱 Name of disease _____										
生活型態	※ 請勾選最合適的選項 Tick the box that best describes your lifestyle:									
	1. 過去7天內(不含假日), 睡眠習慣 How much did you sleep during the past 7 days (not including weekends, or days off)? <input type="checkbox"/> ①每日睡足7小時≥7 hours a day <input type="checkbox"/> ②不足7小時<7 hours a day <input type="checkbox"/> ③時常失眠 I suffer from insomnia					7. 常覺得焦慮、憂鬱嗎 Do you feel worried or depressed? <input type="checkbox"/> ①沒有 No <input type="checkbox"/> ②很少 Seldom <input type="checkbox"/> ③時常 Often				
	2. 過去7天內(不含假日), 早餐習慣 How many days did you eat breakfast during the past 7 days (not including weekends, or days off)? <input type="checkbox"/> ①都不吃 Never <input type="checkbox"/> ②有時吃 Seldom: _____天(days) <input type="checkbox"/> ③每天吃, 幾點吃 Every day at? _____點 (time)					8. 常覺得胸悶嗎 Do you regularly feel chest discomfort? <input type="checkbox"/> ①沒有 No <input type="checkbox"/> ②很少 Seldom <input type="checkbox"/> ③時常 Often 9. 常覺得胃痛嗎 Do you regularly feel stomach discomfort? <input type="checkbox"/> ①沒有 No <input type="checkbox"/> ②很少 Seldom <input type="checkbox"/> ③時常 Often 10. 常覺得頭痛嗎 Do you regularly have headaches? <input type="checkbox"/> ①沒有 No <input type="checkbox"/> ②很少 Seldom <input type="checkbox"/> ③時常 Often				
	3. 過去一個月內(不含假日及寒暑假), 若以每週至少運動3次, 每次至少30分鐘為基準, 心跳達每分鐘130下, 您做到了嗎 During the past month (not including weekends, days off, or winter or summer vacation), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time? : <input type="checkbox"/> ①有 Yes <input type="checkbox"/> ②沒有 No					11. 月經情況(女生回答) Menstrual history (women only): (1) 初次月經 Your age at first menstruation: <input type="checkbox"/> ①無 Haven't begun menstruation yet <input type="checkbox"/> ②有, 初經年齡 Age at first period: _____歲 (2) 月經週期 Length of menstrual cycle? <input type="checkbox"/> ①≤20天 <input type="checkbox"/> ②21-40天 <input type="checkbox"/> ③≥41天 <input type="checkbox"/> ④不規律 irregular (差異7天以上) (3) 有無經痛現象 Do you have painful menstrual periods? <input type="checkbox"/> ①沒有 No <input type="checkbox"/> ②輕微 Light pain <input type="checkbox"/> ③嚴重 Severe pain				
4. 過去一個月內, 吸菸行為 During the past month, did you smoke? <input type="checkbox"/> ①不吸菸 No <input type="checkbox"/> ②時常吸菸 Often <input type="checkbox"/> ③每天吸菸 Every day, _____支/天 cigarettes per day <input type="checkbox"/> ④已戒除 Quit					12. 排便習慣 Bowel habits: 過去7天內, 多久排便一次 During the past 7 days, how often did you defecate? <input type="checkbox"/> ①每天至少一次 At least once every day <input type="checkbox"/> ②兩天 Once in 2 days <input type="checkbox"/> ③三天 Once in 3 days <input type="checkbox"/> ④四天以上 Once in 4 or more days					
5. 過去一個月內, 喝酒行為 During the past month, did you drink alcohol? <input type="checkbox"/> ①不喝酒 No <input type="checkbox"/> ②時常喝酒 Often <input type="checkbox"/> ③每天喝酒 Every day, _____杯/天 glasses per day <input type="checkbox"/> ④已戒除 Quit (1杯的定義: 啤酒 330 ml, 葡萄酒 120 ml, 烈酒 45 ml)					13. 網路使用習慣 Internet use: 過去7天內(不含假日)每日除了上課及作功課需要之外, 累積網路使用的時間 During the past seven days (not including weekends, or days off), how many hours did you use the internet every day, apart from when doing homework or in class? <input type="checkbox"/> ①每天少於1小時 <input type="checkbox"/> ②每天約1-2小時 <input type="checkbox"/> ③每天約2-4小時 <input type="checkbox"/> ④每天約4-5小時 <input type="checkbox"/> ⑤每天約5小時或以上					
自我健康評估	1. 過去一個月, 一般來說, 您認為您目前的健康狀況是 In general, during the past month, would you say your health is? <input type="checkbox"/> ①極好的 Excellent <input type="checkbox"/> ②很好 Very good <input type="checkbox"/> ③好 Good <input type="checkbox"/> ④普通 Fair <input type="checkbox"/> ⑤不好 Poor									
	2. 過去一個月, 一般來說, 您認為您目前的心理健康是 In general, during the past month, would you say your mental health is? <input type="checkbox"/> ①極好的 Excellent <input type="checkbox"/> ②很好 Very good <input type="checkbox"/> ③好 Good <input type="checkbox"/> ④普通 Fair <input type="checkbox"/> ⑤不好 Poor									
	※ 目前有哪些健康問題? 請敘述: Do you currently have any health concerns? Please give details:									

