
National Taipei University of Nursing and Health Sciences



MEDICAL REPORT

FOR

2024

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).

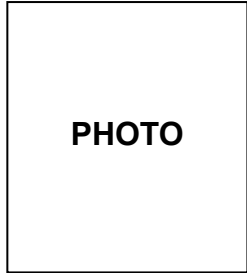
PART 1: HEALTH DECLARATION

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"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
German Measles (Rubella)	<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"/>

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 : <u> R </u> <u> L </u>	
EYES : <input type="checkbox"/> normal <input type="checkbox"/> color anomalous <input type="checkbox"/> other_____	
EAR/NOSE/THROAT : <input type="checkbox"/> normal <input type="checkbox"/> auditory meatus abnormal <input type="checkbox"/> cleft lip and palate <input type="checkbox"/> impending infarction <input type="checkbox"/> allergic rhinitis <input type="checkbox"/> chronic rhinitis <input type="checkbox"/> other_____	
NECK : <input type="checkbox"/> normal <input type="checkbox"/> wryneck <input type="checkbox"/> goiter <input type="checkbox"/> the lymphoid swelling of gland is big <input type="checkbox"/> other_____	
CHEST : <input type="checkbox"/> normal <input type="checkbox"/> thoracic anomaly <input type="checkbox"/> core noise <input type="checkbox"/> arrhythmias <input type="checkbox"/> other_____	
CHEST X RAY : <input type="checkbox"/> normal <input type="checkbox"/> advertise for like the tuberculosis <input type="checkbox"/> pleura effusion <input type="checkbox"/> thoracic abnormality <input type="checkbox"/> tuberculosis calcify <input type="checkbox"/> the spinal column side is curved up <input type="checkbox"/> cardiac hypertrophy <input type="checkbox"/> bronchiectasis <input type="checkbox"/> other_____	
ABDOMEN : <input type="checkbox"/> normal <input type="checkbox"/> hepatomegaly <input type="checkbox"/> splenomegaly <input type="checkbox"/> hernia <input type="checkbox"/> other_____	
SPINAL COLUMN ARMS AND LEGS : <input type="checkbox"/> normal <input type="checkbox"/> scoliosis <input type="checkbox"/> frog limb <input type="checkbox"/> articulation deformity <input type="checkbox"/> edema <input type="checkbox"/> other_____	
SKIN : <input type="checkbox"/> normal <input type="checkbox"/> wart <input type="checkbox"/> purple plague <input type="checkbox"/> scabies <input type="checkbox"/> a dermatitis <input type="checkbox"/> other_____	
MOUTH CAVITY : <input type="checkbox"/> normal <input type="checkbox"/> oral hygiene is poor <input type="checkbox"/> calculus <input type="checkbox"/> gingivitis <input type="checkbox"/> milk tooth <input type="checkbox"/> other_____	
<u>Urine Test:</u>	
NAD <input type="text"/>	WBC <input type="text"/> RBC <input type="text"/> PROTEIN <input type="text"/> CLUCOSE <input type="text"/>
<u>Hepatitis B Test:</u>	
POSITIVE <input type="text"/>	NEGATIVE <input type="text"/>

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?

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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 :.....

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Not valid if without the hospital or clinic's seal