STRICTLY CONFIDENTIAL Student I.D. No: _____

College:
Faculty:
Department:

香 港 中 文 大 學 保 健 處

THE CHINESE UNIVERSITY OF HONG KONG

UNIVERSITY HEALTH SERVICE

健康記錄表

HEALTH HISTORY FORM

Photo

Name: (Surname, Other names) _____ (Chinese) _____

Sex: M/ F Date of Birth: _____ Place of Birth: _____ Marital Status: Single/ Married

Home Address: _____ Phone: Home: _____

_____ Mobile: _____

Correspondence Address (if different): _____ Nationality: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

Address: _____

FAMILY HISTORY:

Relation	Sex/Age	Occupation	State of Health 健康狀況	Do your family member ever had the followings: (please √)						If Deceased Cause & Age of Death
				Cancer 癌症	Heart Disease 心臟病	Hypertension 高血壓	Diabetes 糖尿病	Hyper-cholesterolemia 高膽固醇	Mental Illness 精神病	
Father										
Mother										
Brothers & Sisters										

HEALTH PROBLEMS:

Have you ever had the followings?

		Yes	No			Yes	No			Yes	No
Allergic Rhinitis	鼻 敏 感	☐	☐	Heart Disease	心 臟 病	☐	☐	Acute Hepatitis	急性肝炎	☐	☐
Asthma	哮 喘	☐	☐	Hypertension	高 血 壓	☐	☐	Hepatitis B Carrier	乙肝帶菌者	☐	☐
Eczema/Dermatitis	濕疹/皮膚炎	☐	☐	Diabetes Mellitus	糖 尿 病	☐	☐	Tuberculosis	肺結核病	☐	☐
Thyroid Disease	甲狀腺病	☐	☐	Hypercholesterolemia	高膽固醇	☐	☐	Venereal Disease	性 病	☐	☐
Ulcer Pain	胃 痛	☐	☐	Kidney Disease	腎 病	☐	☐	Mental Illness	精 神 病	☐	☐
Anaemia	貧 血	☐	☐	Epilepsy	羊 癇 症	☐	☐	Other Diseases	其他病症	☐	☐
Operation	手 術	☐	☐	Hospitalization	住 院	☐	☐				

If yes, please specify (Date; Duration; Treatment & Follow-up):

LONG TERM MEDICATIONS 長期服用藥物

	Name	Dosage & Frequency	Date started (if known)
1.			
2.			

Are you **ALLERGIC** to any food/ medications? Yes ☐ No ☐ If Yes, please specify?
你是否對某種藥物/食物敏感？ 如有，請列明。 _____

MENSTRUAL HISTORY (For female students only) 月經週期 (只適用於女生)

Age of first menstruation 首次月經年齡: _____ Duration between periods 月經週期: _____ Days Number of days of menses 月經日數: _____ Days

Quantity of menses 月經流量: ☐ scanty 微量 ☐ moderate 適中 ☐ excessive 很多

Menstrual Pain 經痛: ☐ nil 沒有 ☐ mild 輕微 ☐ moderate 中等 ☐ severe 嚴重

Do you smoke?	Yes ☐ No ☐	If yes, please specify how many?	_____ pack /day	_____years
Do you drink alcohol?	Yes ☐ No ☐	If yes, please specify how much?	_____ drinks /week	

In the past 3 months, did you have: 最近三個月內，你曾否有：	**Yes**	**No**
(i) Cough for more than 4 weeks? 咳逾四星期？	☐	☐
(ii) Cough with blood stained sputum? 咳血現象？	☐	☐
(iii) Unexplained low grade fever? 不明原因的持續發燒？	☐	☐
(iv) History of contact with T.B. patients? 曾與肺結核病人接觸？	☐	☐

	Yes	**No**
Do you frequently have insomnia, feel anxious or emotional upset? 你是否經常失眠、焦躁不安或情緒不穩定？	☐	☐
Do you need counseling or like to discuss confidentially with the health staff for your personal, health, social or emotional problem? 你是否想與醫護人員單獨商討你個人健康、心理輔導或其他指導？	☐	☐

	Yes	**No**
Do you have any physical handicap which may require special provisions to adjust to university life? 你傷殘與否？是否需要援助？	☐	☐
Do you have amblyopia? 你是否弱視(視力模糊，不能用鏡片矯正)？	☐	☐
Are you troubled by any defect in speech? 你是否有言語障礙？	☐	☐
Do you have any impairment of hearing? 你是否弱聽？	☐	☐

IMMUNIZATION 防疫注射 (Please √ and including dates if possible)

	First Dose	Second Dose	Third dose		First Dose	Second Dose
Hepatitis A 甲型肝炎				MMR 痲疹,腮腺炎,德國痲疹		
Hepatitis B 乙型肝炎				BCG 卡介苗		
HPV Vaccine 預防子宮頸癌疫苗				Chickenpox 水痘		
Poliomyelitis 小兒麻痺				Influenza 流感		
DPT (Triple Vaccine) 白喉,破傷風,百日咳						
Diaphtheria-Tetanus 白喉,破傷風				Other Vaccines 其他疫苗		
Tetanus Toxoid 破傷風類毒素						

Date:_____ Student Signature:_____

For Official Use

Body Weight (kg) _____

Height (m) _____

BMI _____

Blood Pressure _____ / _____

Remarks _____

RETURN COMPLETED FORM TO:

The Director

University Health Service

The Chinese University of Hong Kong

Shatin, N.T.