

College: _____

Faculty: _____

Department: _____

Student I.D. No: _____

香港中文大學保健處
THE CHINESE UNIVERSITY OF HONG KONG
UNIVERSITY HEALTH SERVICE

All information is STRICTLY CONFIDENTIAL and will become an essential part of your personal and confidential health record at the University.

HEALTH HISTORY FORM

Name: (Surname/Other names/(in Chinese) _____ (_____))
 Sex: M/F* Date of Birth: _____ Place of Birth: _____ Marital Status: Single/Married*
 Home Address: _____ Phone: _____
 _____ Mobile Phone/Pager: _____
 Correspondence Address (if different): _____

WHOM TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____
 Address: _____ Phone: _____

FAMILY HISTORY										
Relation	Age/Sex	Occupation	State of Health	If Dead Cause & Age	Has any family member ever had the following: (please ✓)					
					Cancer 癌症	Diabetes 糖尿病	Heart Disease 心臟病	Hypertension 高血壓	Mental Illness 精神病	Others 其他
Father										
Mother										
Brother & Sister										

Name and address of family doctor (if any) _____
 Did you have any previous medical check up? (if yes, when & where?) _____
 Is there any abnormal finding? _____

HEALTH PROBLEMS:

Did you or do you have the following:

	Yes	No		Yes	No		Yes	No
Anaemia 貧血	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension 高血壓	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease 甲狀腺病	<input type="checkbox"/>	<input type="checkbox"/>
Asthma 哮喘	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease 腎病	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis 肺結核病	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus 糖尿病	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness 精神病	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Pain 胃痛	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy 羊癇症	<input type="checkbox"/>	<input type="checkbox"/>	Painful Joints 關節痛	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease 性病	<input type="checkbox"/>	<input type="checkbox"/>
Gastro-intestinal Bleeding 腸胃出血	<input type="checkbox"/>	<input type="checkbox"/>	Piles 痔瘡	<input type="checkbox"/>	<input type="checkbox"/>	Others 其他	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease 心臟病	<input type="checkbox"/>	<input type="checkbox"/>	Poliomyelitis 小兒麻痺	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis 肝炎	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease 皮膚病	<input type="checkbox"/>	<input type="checkbox"/>			

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

Hospital Admission Yes No
 Reason: Operation Physical Illness Mental Illness Accidental/Athletic Injury
 Other Details (Date; Place etc.): _____

	Yes	No	Don't Know
Are you ALLERGIC to any drugs/food? If yes, please specify _____ 你是否對某種藥物/食物敏感? 如有, 請列明。	<input type="checkbox"/>	<input type="checkbox"/>	
Are you a hepatitis B carrier? _____ 你是否乙型肝炎帶菌者?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 3 weeks? 咳逾三星期？	<input type="checkbox"/>	<input type="checkbox"/>
(ii)	Coughing with blood stained sputum? 咳血現象？	<input type="checkbox"/>	<input type="checkbox"/>
(iii)	Unexplained low grade fever? 不明原因的持續發燒？	<input type="checkbox"/>	<input type="checkbox"/>
(iv)	History of contact with T.B. patients? 曾與肺結核病人接觸？	<input type="checkbox"/>	<input type="checkbox"/>

		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？		<input type="checkbox"/>	<input type="checkbox"/>
Do you need counselling 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？		<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? (more than 6 cigarettes per day) Are you a frequent alcohol drinker? (more than four times per week)		<input type="checkbox"/>	<input type="checkbox"/>

		Yes	No
Do you have any physical handicap which may require special provisions to adjust to university life? 你有傷殘否？需否援助？		<input type="checkbox"/>	<input type="checkbox"/>
Do you have amblyopia? 你是否弱視（視力模糊，不能用鏡片矯正）？		<input type="checkbox"/>	<input type="checkbox"/>
Are you troubled by any defect in speech?		<input type="checkbox"/>	<input type="checkbox"/>
Do you have impairment of hearing?		<input type="checkbox"/>	<input type="checkbox"/>

MENSTRUAL HISTORY (for female students)

Age of onset: _____ Duration of period: _____ Days Interval between periods: _____ Days

Pain: nil mild severe

Quantity: scanty moderate excessive

IMMUNIZATION 防疫接種 (Please ✓ and including dates if possible)						
Hepatitis A 甲型肝炎					BCG 卡介苗	
Hepatitis B 乙型肝炎					Hepatitis B (Booster) 乙型肝炎 (加強劑)	
Twinrix 甲乙型肝炎					MMR 腮腺, 麻疹, 德國麻疹	
DPT (Triple Vaccine) 白喉, 破傷風, 百日咳					Measles 麻疹	
Diphtheria-Tetanus 白喉, 破傷風					Rubella 德國麻疹	
Poliomyelitis 小兒麻痺					Chickenpox 水痘	
Tetanus Toxoid 破傷風					Other Vaccine 其他防疫	

Body weight _____ kg

Body height _____ m

Date: _____

Student Signature: _____

Do not write below double line

For official use only

Form screened
Priority of appointment

RETURN COMPLETED FORM TO:

The Director
University Health Service
The Chinese University of Hong Kong
Shatin, N.T.