

|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 學號                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 班級座號                                                                                                                                                                                                                                                                                                                                   |                                | 姓名                                                      |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 檢查日期                        | 年 月 日                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 檢查項目                        | 檢查結果（採勾選方式，「其他」未詳列項目請以中文載明。）                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         | 醫事人員簽章       |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 血壓                          | ①_____／_____mmHg 脈搏： _____次/分 ②_____／_____mmHg 脈搏： _____次/分                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 聽力                          | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 左耳聽力弱 <input type="checkbox"/> 右耳聽力弱 <input type="checkbox"/> 其他_____                                                                                                                                                                                                                                         |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 辨色力                         | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 辨色力異常 <input type="checkbox"/> 其他_____                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 眼睛                          | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 斜視：_____ <input type="checkbox"/> 睫毛倒插 <input type="checkbox"/> 眼球震顫 <input type="checkbox"/> 眼瞼下垂 <input type="checkbox"/> 其他_____                                                                                                                                                                           |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 耳鼻喉                         | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 耳膜破損（右、左） <input type="checkbox"/> 耳道畸形（右、左） <input type="checkbox"/> 耳前瘻管（右、左） <input type="checkbox"/> 唇顎裂<br><input type="checkbox"/> 構音異常 <input type="checkbox"/> 耵聍栓塞（右、左） <input type="checkbox"/> 扁桃腺腫大 <input type="checkbox"/> 過敏性鼻炎 <input type="checkbox"/> 慢性鼻炎 <input type="checkbox"/> 其他_____ |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 頭頸                          | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 斜頸 <input type="checkbox"/> 異常腫塊（ <input type="checkbox"/> 甲狀腺腫 <input type="checkbox"/> 淋巴腺腫大 <input type="checkbox"/> 其他異常腫塊_____） <input type="checkbox"/> 其他_____                                                                                                                                         |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 胸部<br>(胸腔及外觀)               | <input type="checkbox"/> 無明顯異常<br><input type="checkbox"/> 不同意受檢                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> 胸廓異常 <input type="checkbox"/> 氣喘<br><input type="checkbox"/> 心肺疾病（ <input type="checkbox"/> 心雜音 <input type="checkbox"/> 心律不整 <input type="checkbox"/> 呼吸聲異常 <input type="checkbox"/> 其他心肺疾病_____）                                                                                                            |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 腹部                          | <input type="checkbox"/> 無明顯異常<br><input type="checkbox"/> 不同意受檢                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> 腹部異常腫大 <input type="checkbox"/> 其他_____                                                                                                                                                                                                                                                                       |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 脊柱四肢                        | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 脊柱側彎 <input type="checkbox"/> 肢體畸形（ <input type="checkbox"/> 多併指（趾） <input type="checkbox"/> 關節變形 <input type="checkbox"/> 其他肢體畸形） <input type="checkbox"/> 蹲距困難 <input type="checkbox"/> 其他_____                                                                                                             |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 泌尿生殖                        | <input type="checkbox"/> 無明顯異常<br><input type="checkbox"/> 不同意受檢                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> 隱罩 <input type="checkbox"/> 陰囊腫大 <input type="checkbox"/> 包皮異常 <input type="checkbox"/> 精索靜脈曲張 <input type="checkbox"/> 其他_____ ※僅限男生受檢                                                                                                                                                                       |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 皮膚                          | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 癬 <input type="checkbox"/> 疣 <input type="checkbox"/> 紫斑 <input type="checkbox"/> 疥瘡 <input type="checkbox"/> 溼疹 <input type="checkbox"/> 異位性皮膚炎 <input type="checkbox"/> 其他_____                                                                                                                             |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 口腔                          | <div><input type="checkbox"/>D未治療齲齒 <input type="checkbox"/>F已治療齲齒 恆牙第一大臼齒齲齒經驗(上顎<input type="checkbox"/>16 <input type="checkbox"/>26、下顎<input type="checkbox"/>36 <input type="checkbox"/>46)<br/><input type="checkbox"/>SF恆牙白齒窩溝封填 <input type="checkbox"/>口腔衛生不良 <input type="checkbox"/>咬合不正 <input type="checkbox"/>牙結石 <input type="checkbox"/>牙齦炎 <input type="checkbox"/>口腔黏膜異常<br/><input type="checkbox"/>牙周病 <input type="checkbox"/>h乳牙待拔牙 <input type="checkbox"/>E待拔牙 <input type="checkbox"/>S贅生牙 <input type="checkbox"/>M缺牙 <input type="checkbox"/>G阻生牙</div> <div>牙齒位置圖</div> <div>D 齲齒、F 已矯治、SF 窩溝封填、h 乳牙待拔牙、E 待拔牙、S 贅生牙、M 缺牙、G 阻生牙</div> <div>E 待拔牙定義：1. 乳牙齲齒嚴重無法修復者 2. 恆牙膿瘍並合併degree2以上之搖動者 3. 因齲齒造成的殘根</div> <table><tr><td>18</td><td>17</td><td>16</td><td>15</td><td>14</td><td>13</td><td>12</td><td>11</td><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td><td>28</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td colspan="3" rowspan="3">上<br/><br/><br/>右<br/><br/><br/>下</td><td>55</td><td>54</td><td>53</td><td>52</td><td>51</td><td>61</td><td>62</td><td>63</td><td>64</td><td>65</td><td colspan="3" rowspan="3">左<br/><br/><br/>下<br/><br/><br/>下</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>85</td><td>84</td><td>83</td><td>82</td><td>81</td><td>71</td><td>72</td><td>73</td><td>74</td><td>75</td></tr><tr><td>48</td><td>47</td><td>46</td><td>45</td><td>44</td><td>43</td><td>42</td><td>41</td><td>31</td><td>32</td><td>33</td><td>34</td><td>35</td><td>36</td><td>37</td><td>38</td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         | 18           | 17        | 16                                                        | 15 | 14 | 13 | 12 | 11 | 21                          | 22 | 23 | 24 | 25 | 26 | 27 | 28 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | 上<br><br><br>右<br><br><br>下 |  |  | 55 | 54 | 53 | 52 | 51 | 61 | 62 | 63 | 64 | 65 | 左<br><br><br>下<br><br><br>下 |  |  |  |  |  |  |  |  |  |  |  |  | 85 | 84 | 83 | 82 | 81 | 71 | 72 | 73 | 74 | 75 | 48 | 47 | 46 | 45 | 44 | 43 | 42 | 41 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18                          | 17                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 16                                                                                                                                                                                                                                                                                                                                     | 15                             | 14                                                      | 13           | 12        | 11                                                        | 21 | 22 | 23 | 24 | 25 | 26                          | 27 | 28 |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 上<br><br><br>右<br><br><br>下 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        | 55                             | 54                                                      | 53           | 52        | 51                                                        | 61 | 62 | 63 | 64 | 65 | 左<br><br><br>下<br><br><br>下 |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        | 85                             | 84                                                      | 83           | 82        | 81                                                        | 71 | 72 | 73 | 74 | 75 |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 48                          | 47                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 46                                                                                                                                                                                                                                                                                                                                     | 45                             | 44                                                      | 43           | 42        | 41                                                        | 31 | 32 | 33 | 34 | 35 | 36                          | 37 | 38 |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 尿液檢查                        | 初查日期： 年 月 日                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                        | 複查日期： 年 月 日                    |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 尿蛋白（ ） 尿 糖（ ）<br>尿潛血（ ） 酸鹼度（ ）                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                        | 尿蛋白（ ） 尿 糖（ ）<br>尿潛血（ ） 酸鹼度（ ） |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 血液檢查                        | 實驗室檢查項目                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 初檢報告                                                                                                                                                                                                                                                                                                                                   |                                | 判讀                                                      | 實驗室檢查項目      | 初檢報告      | 判讀                                                        |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 白血球 (10 <sup>3</sup> /μL)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | SGOT (U/L)   |           | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常   |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 紅血球 (10 <sup>6</sup> /μL)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | SGPT (U/L)   |           | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常   |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 血小板 (10 <sup>3</sup> /μL)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | 肌酸酐 (mg/dl)  |           | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常   |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 血色素 (g/dl)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | 尿酸 (mg/dl)   |           | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常   |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 血球容積比Hct (%)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | 總膽固醇 (mg/dl) |           | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常   |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             | 平均血球容積MCV (fl)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                        |                                | <input type="checkbox"/> 正常 <input type="checkbox"/> 異常 | B 型肝炎表面抗原    |           | <input type="checkbox"/> 有反應 <input type="checkbox"/> 無反應 |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         | B 型肝炎表面抗體    |           | <input type="checkbox"/> 有反應 <input type="checkbox"/> 無反應 |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 胸部X光                        | <input type="checkbox"/> 無明顯異常                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> 異常 <input type="checkbox"/> 疑似肺結核病癥 <input type="checkbox"/> 肺結核鈣化 <input type="checkbox"/> 胸廓異常 <input type="checkbox"/> 肋膜腔積水 <input type="checkbox"/> 脊柱側彎<br><input type="checkbox"/> 心臟肥大 <input type="checkbox"/> 支氣管擴張 <input type="checkbox"/> 其他_____                                                |                                |                                                         |              | X光編號：     |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 總評建議                        | <input type="checkbox"/> 無明顯異常 <input type="checkbox"/> 有異常，需接受_____科醫師診治<br><input type="checkbox"/> 其他建議：_____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              | 承辦檢查廠商蓋章  |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 臨時性檢查                       | 檢查名稱                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 檢查日期                                                                                                                                                                                                                                                                                                                                   |                                | 檢查單位                                                    | 檢查結果         | 轉介複查追蹤及備註 |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| 健康管理                        | 學生健康檢查結果追蹤矯治情形： <input type="checkbox"/> 1. 已完成複查與矯治，科別：_____<br><input type="checkbox"/> 2. 需持續追蹤矯治項目：_____<br><br>個案管理摘要紀載：                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 疫苗接種                        | 新冠肺炎疫苗接種日期：____年____月____日、____年____月____日、____年____月____日、____年____月____日<br>流感疫苗接種日期：____年____月____日、____年____月____日、____年____月____日、____年____月____日                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                        |                                |                                                         |              |           |                                                           |    |    |    |    |    |                             |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                             |  |  |    |    |    |    |    |    |    |    |    |    |                             |  |  |  |  |  |  |  |  |  |  |  |  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |