

32 Tasks Involving Mercury and Its Inorganic Compounds  
Special Physical Examination and Health Examination Record Form

I. Basic Information

1. Name:            2. Sex: ☐ Male ☐ Female 3. ID/Passport Number: \_\_\_\_\_  
4. Date of Birth (YYYY/MM/DD): \_\_\_\_\_  
5. Date of Employment (YYYY/MM/DD): \_\_\_\_\_  
6. Date of Examination (YYYY/MM/DD): \_\_\_\_\_  
7. Name of Company (Facilities): \_\_\_\_\_ Address: \_\_\_\_\_

II. Employment History

1. Previously worked as \_\_\_\_\_ from (YYYY/MM)\_\_\_\_\_ to (YYYY/MM)\_\_\_\_\_,  
\_\_\_\_(Years)\_\_\_\_(Months) in total  
2. Currently working as \_\_\_\_\_ from (YYYY/MM)\_\_\_\_\_ to (YYYY/MM)\_\_\_\_\_,  
\_\_\_\_(Years)\_\_\_\_(Months) in total  
3. Average working hours of the tasks involving mercury and its inorganic  
compounds is \_\_\_\_\_ hours per day

III. Reason for Examination:

- ☐ New Employee    ☐ Change of Work  
☐ Periodic Check-up    ☐ Health Tracking Examination

IV. Past Medical History

Do you have any chronic diseases? (Please mark the appropriate items)

1. Neuropsychiatric: ☐ Psychiatric disorders    ☐ Encephalopathy (Central nervous system disease)    ☐ Peripheral neuropathy    ☐ Epilepsy    ☐ None  
2. Respiratory system: ☐ Asthma    ☐ Chronic tracheitis, Emphysema    ☐ Pulmonary edema    ☐ Lung cancer    ☐ None  
3. Skin system: ☐ Irritant dermatitis    ☐ Allergic dermatitis    ☐ Skin rash  
☐ Pigmentation    ☐ None  
4. Endocrine system: ☐ Thyroid disease    ☐ Diabetes    ☐ None  
5. Others: ☐ Liver disease    ☐ Kidney disease    ☐ \_\_\_\_\_ ☐ None

V. Lifestyle Habits

1. Have you ever smoked in the last month?  
☐ Never    ☐ Occasionally, not every day.  
☐ Almost daily, on average \_\_\_\_ cigarettes a day, and smoked for \_\_\_\_ years

- ☐ Already quit for \_\_\_\_ years and \_\_\_\_ months.
2. Have you ever chewed betel nuts in the last six months?
- ☐ Never ☐ Occasionally, not every day.
- ☐ Almost daily, on average \_\_\_\_ a day, for \_\_\_\_ years
- ☐ Already quit for \_\_\_\_ years and \_\_\_\_ months.
3. Have you ever drunk alcohol in the last month?
- ☐ Never ☐ Occasionally, not every day.
- ☐ Almost daily, on average \_\_\_\_ times a week, most often drink \_\_\_\_ (alcohol brand or name), \_\_\_\_\_ (how many) bottles each time.
- ☐ Already quit for \_\_\_\_ years and \_\_\_\_ months.

#### VI. Self-reported Symptoms

In the previous 3 months or at work, have you frequently suffered from any of the symptoms listed below? (Please mark the appropriate items)

1. Nervous system: ☐ Hand tremors ☐ Headache ☐ Vertigo ☐ Weakness and soreness of hands and feet ☐ Decreased sense of balance
2. Mental state: ☐ Emotional instability ☐ Poor memory ☐ Fatigue ☐ Restlessness ☐ Concentration difficulty.
3. Respiratory system: ☐ Cough ☐ Chest tightness, chest pain ☐ Dyspnea
4. Digestive system: ☐ Loss of appetite ☐ Nausea, vomiting ☐ Weight loss
5. Urinary system: ☐ Decreased urine output ☐ Eyelids, lower limbs edema
6. Skin system: ☐ Oral ulcers ☐ Skin rash ☐ Redness, swelling, blisters, dryness, tingling, or peeling of the exposed part of the skin
7. Others: ☐ Hearing loss ☐ Vision loss ☐ Gum inflammation ☐ Burning or metallic taste in the mouth ☐ Joint pain ☐ \_\_\_\_\_
8. ☐ None of the above.

#### VII. Workplace Environmental Monitoring Information

1. Does your business entity arrange workplace environmental monitoring according to Labor Workplace Monitoring Regulations?
- ☐ Yes (please answer the next question) ☐ No
2. Have the reports of workplace environmental monitoring been uploaded to the management platform website of the Occupational Safety and Health Administration, Ministry of Labor?
- ☐ Yes (please answer the next question) ☐ No
3. The number of Business Entities \_\_\_\_\_ that are using the management platform website of the Occupational Safety and Health Administration, Ministry of Labor.

===== [The following is filled in by medical staff] =====

### VIII. Items of Examination

#### 1. Basic Items:

Height: \_\_\_\_\_cm, Weight: \_\_\_\_\_kg, Waist circumference: \_\_\_\_\_cm,  
Blood pressure: \_\_\_\_/\_\_\_\_ mmHg,  
Visual acuity (corrected): Left /Right: \_\_\_\_ /\_\_\_\_,  
Color vision test: ☐Normal ☐Abnormal

#### 2. Systemic physical check-up:

- (1) Oral and nasal cavity
- (2) Eyes
- (3) Respiratory system
- (4) Nervous system (central and peripheral)
- (5) Gastrointestinal system
- (6) Kidney
- (7) Skin
- (8) Mental state

#### 3. Chest X-ray: \_\_\_\_\_

4. Blood test: Red blood cell count \_\_\_\_\_ Hemoglobin \_\_\_\_\_ Hematocrit \_\_\_\_\_  
White blood cell count \_\_\_\_\_

5. Biochemical blood test: Creatinine \_\_\_\_\_

6. Urine test: Urine protein \_\_\_\_\_ Urine occult blood \_\_\_\_\_ Urine sediment  
microscopy (cytology) \_\_\_\_\_

7. Urine mercury test: \_\_\_\_\_

### IX. Health Tracking Examination

1. Date of Health Examinations (YYYY/MM/DD): \_\_\_\_\_

#### 2. Items

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_
- (3) \_\_\_\_\_
- (4) \_\_\_\_\_
- (5) \_\_\_\_\_

### X. Hierarchical Health Management:

- ☐ Level 1 Management  
☐ Level 2 Management

☐ Level 3 Management (Clinical diagnosis should be indicated) \_\_\_\_\_

☐ Level 4 Management (Clinical diagnosis should be indicated) \_\_\_\_\_

XI. Follow-up and Precautions:

1. ☐ The examination results are roughly normal. Please have a periodic check-up.
2. ☐ The examination results are partially abnormal and need medical follow-up at \_\_\_\_\_ medical institutions before \_\_\_\_.(YYYY/MM/DD)
3. ☐ The examination results are abnormal, \_\_\_\_\_ task should be restricted.  
(Please explain the reason: \_\_\_\_\_).
4. ☐ The examination results are abnormal. The employee should have a health tracking examination in an occupational medicine outpatient clinic before \_\_\_\_.  
(YYYY/MM/DD)
5. ☐ The examination results are abnormal, the task should be readjusted.
  - ☐ Shorten working hours(Please explain the reason: \_\_\_\_\_).
  - ☐ Change job content (Please explain the reason: \_\_\_\_\_).
  - ☐ Change workplace (Please explain the reason: \_\_\_\_\_).
  - ☐ Other: \_\_\_\_\_ (Please explain the reason: \_\_\_\_\_).
6. ☐ Others: \_\_\_\_\_.

Medical institution: \_\_\_\_\_, Telephone number: \_\_\_\_\_, Address: \_\_\_\_\_

Physician Name (Signature) and certificate number: \_\_\_\_\_

Physician of hierarchical health management (Signature): \_\_\_\_\_and Certificate number of the physician: \_\_\_\_\_

Note:

The urine mercury test is only for on-job workers, not for new employees or workers who change the task.