

## 22 Tasks Involving Bipyridine or Paraquat

### 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 bipyridine or paraquat task 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. Skin system: ☐ Contact dermatitis ☐ Skin keratosis ☐ Dark spots  
☐ Suspected skin cancer ☐ None
2. Other: ☐ \_\_\_\_\_ ☐ 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 quitted 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. Cardiovascular system: ☐ Palpitation ☐ Dizziness ☐ Headache
2. Respiratory system: ☐ Cough ☐ Productive cough ☐ Dyspnea ☐ Chest pain
3. Skin system: ☐ Redness, swelling, blisters, dryness, tingling, or peeling of the exposed part of the skin ☐ Slow wound healing ☐ Skin ulcers ☐ Subcutaneous nodules.
4. Others: ☐ \_\_\_\_\_ ☐ none

===== [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) Skin and nail

#### XIII. Health Tracking Examination

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

##### 2. Items

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

#### IX. 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) \_\_\_\_\_

X. 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: \_\_\_\_\_