01 Tasks Involving High-Temperature

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. Exposed to high temperature in workplaces, on average, _____hours per day.

4. Have you received Heat Acclimatization Training? ☐Yes, __ days ☐No

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. Cardiovascular system:☐Hypertension ☐Ischemic Heart Disease
   ☐Angina Pectoris ☐Myocardial Infarction ☐None
2. Respiratory system:☐Asthma ☐None
3. Endocrine system:☐Diabetes Mellitus ☐Hyperthyroidism ☐None
4. Urinary system:☐Renal Function Impairment ☐Kidney Stone ☐None
5. Reproductive system:☐Infertility ☐None
6. Skin system:☐Skin Rash ☐Large area burn scar ☐Anhidrosis ☐None
7. Immune Disease:☐Severe Bacterial or Viral Infections ☐_____☐None
8. Long-term medication:☐Diuretics ☐Antihypertensives ☐Sedatives
   ☐Antiepileptic Drugs ☐Anticoagulants ☐Anticholinergic agents
   ☐Antipsychotics
   ☐Thyroxine ☐Weight-loss Drug ☐Stimulants ☐Other _____☐None
9. Heat-Related Illnesses:☐Heat Cramps ☐Heat Syncope ☐Heat Exhaustion
   ☐Heat Stroke ☐Rhabdomyolysis ☐None

10. 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 quitted 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 quitted 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.
4. Have you exercised for more than 30 minutes in the past month?
   □Never □Less than 3 days a week □More than 3 days a week

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:□Chest tightness or chest pain during exercise
2. Respiratory system:□Shortness of Breath
3. Endocrine system:□Dry Mouth □Polyuria □Weight Loss □Palpitations
   □Hand Tremor □Other _____
4. Urinary system:□Edema □Hematuria □Oliguria or Anuria
5. Skin:□Skin Rash □Abnormal sweating
6. □Other _____
7. □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) Cardiovascular system:
   (2) Respiratory system:
   (3) Neurological system:
   (4) Musculoskeletal system:
   (5) Skin system:
3. ECG: _____
4. Pulmonary function tests (including forced vital capacity (FVC), Forced expiratory-volume in one second (FEV1.0), and FEV1/ FVC ratio): _____
5. Biochemistry Examination of blood:
   Sugar AC: _____ BUN: _____ Creatinine: _____ Sodium: _____
   Potassium: _____ Chloride: _____
6. Blood Count:
   Hemoglobin: _____
7. Urinalysis:
   Protein: _____, Occult blood: ____

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: _____