

03 Tasks Involving Ionizing Radiation

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 ionizing radiation in workplaces, on average, _____hours per day.

III. Reason for Examination:

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

IV. Past Medical History

Have you ever had underlying chronic diseases: (Please mark the appropriate items)?

1. Endocrine system: Thyroid nodules or tumors
Hyperthyroidism/Hypothyroidism None
2. Hematological System: Low white blood cell count Iron deficiency anemia
Thalassemia Aplastic anemia Low platelet count None
3. Hepatic system: HBV infection HCV infection Fatty liver
Alcoholic hepatitis Drug-induced liver injury None
4. Others: Reproductive system disease (Infertility, abnormal menstruation)
Eye disease (cataract) Skin diseases Hypertension Diabetes Mellitus
Chronic kidney disease Heart disease Respiratory disease
Gastrointestinal disease Malignancy Others _____ 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.

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. Endocrine system: Weight gain/loss of more than 3 kg Palpitation
 Constipation or diarrhea
2. Hematological System: Fever Fatigue Dizziness Night Sweat
 Spontaneous subcutaneous bleeding or bruising
3. Respiratory system: Cough Chest pain Breathing difficulties
4. Other: Blurred vision Nausea Vomiting Abdominal pain Skin rash, inflammation, or ulcer Abnormal menstruation Swelling of gingiva
 Others _____
5. None of the above

VII. Workplace Environmental Monitoring Information

1. Does your business entity arrange environmental radiation monitoring or personal radiation detection according to the Ionizing Radiation Protection Act?
- Yes No

===== [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) Head and neck **【Eyes (Cataract), thyroid nodules, tumor, lymph nodes】** :
 - (2) Heart:
 - (3) Lung:
 - (4) Neurological system:
 - (5) Digestive system:
 - (6) Urinary system:
 - (7) Skeleton, joint, and muscle:
 - (5) Skin:
3. Mental status:
 4. Chest X-ray: _____
 5. Pulmonary function tests (including forced vital capacity (FVC), Forced expiratory volume in one second (FEV1.0)): _____
 6. Thyroid function tests: free T4 _____, TSH _____
 7. Biochemistry examination of blood: Alanine transaminase (ALT): _____, Creatinine: _____
 8. Blood Count: Red blood cells: _____, Hemoglobin: _____, Hematocrit: _____, White blood cells: _____, Differential Count: _____, Platelets: _____
 9. Urinalysis: Sugar: _____, Protein: _____, Occult blood: _____, Urine sediment microscopy (cytology): _____

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 Pulmonary function test is only for new employees or workers who change the task, not for on-job workers. However, for those who work in nuclear power plants or nuclear waste storage facilities, this test is still required.