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| **Department of Human Development, Education and Culture**MEDICAL HISTORY **TO BE COMPLETED AND SIGNED BY APPLICANT BEFORE VISITING THE PHYSICIAN** |
| **COMPLETE NAME OF APPLICANT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****SPONSORING COUNTRY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE OF BIRTH**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**AGE**\_\_\_\_\_\_\_ **SEX** **M** **F** **MARITAL** **STATUS**  **M** **S** **W** **D** **SEP**  |
| PAST/CURRENT MEDICAL HISTORY (check box for any “yes” answers) |
|  Recurrent ear infections |  Psychiatric consultation/ Treatment/hospitalization |  Venereal disease |
|  Headaches |  Suicide attempt |  Bone, Joint, back disorder or injury |
|  Dizziness or fainting spells |  Excessive bleeding after surgery or dental work |  Hearing aid/pacemaker/artificial limb/ other physical apparatus  |
|  Paralysis/numbness/tingling |  Asthma |  Motion limitation: physical disability |
|  Epilepsy-fits, seizures (convulsions) |  Pneumonia |  Malaria |
|  Eye disease-glaucoma, etc. |  Chronic cough |  Tuberculosis or Positive TB Test |
|  Wears corrective lenses |  Lung disease |  Chronic or frequent colds |
|  Eye surgery to correct vision |  Frequent indigestion |  Skin disease or skin problem |
|  Lack of vision in either eye |  Stomach, liver intestinal problems |  Diabetes |
|  Chest pain |  Hepatitis or yellow jaundice |  High cholesterol |
|  Heart Trouble |  Kidney disease |  Anemia, Blood problems |
|  High blood pressure |  Bladder disease |  Cancer |
|  Shortness of breath |  Hernia or rupture |  Benign Tumor |
|  Rheumatic Fever |  |  |
| Do you have, or have had: Tuberculosis\_\_\_\_\_\_\_\_\_Diabetes\_\_\_\_\_\_\_\_\_Cancer\_\_\_\_\_\_\_\_\_Headaches\_\_\_\_\_\_\_\_\_\_\_Epilepsy\_\_\_\_\_\_\_\_\_\_Mental Illness\_\_\_\_\_\_Heart Trouble\_\_\_\_\_\_\_\_High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please disclose any chronic or serious physical or psychiatric condition that might affect your full-time participation in the program of study. If so, please provide name of condition, duration (specify dates), and final results. |
| Have you ever been under observation, had medical, psychiatric, or surgical advice or treatment, or have been hospital-confined? If so, please provide name of condition, duration (specify dates), and final results.  |
| To the best of your knowledge and belief, are you in good physical and mental health? Additional History/Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have a primary physician? Please provide your physician’s name and telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| MEDICAL HISTORY |
| 1. What is your occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List any occupational or other hazards to which you have been exposed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you being treated for any condition now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever been absent from work or school for longer than one month’s illness? \_\_\_\_\_\_ If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ And for what illness? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you had any accidents as a result of which you are partially disabled? \_\_\_\_\_ If so, what and when? \_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have any other disability? Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1. Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst in the last 5 years?

 If so, please give his/her name and telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what reason?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of consultation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Are you taking any medicine regularly? \_\_\_\_\_\_\_\_\_\_\_ If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you have any allergies? \_\_\_\_\_\_\_\_\_\_ If so, which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you gained or lost weight during the last three years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If so, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you ever been refused employment on health grounds? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If so, please state reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Have you ever stayed in a tropical country? \_\_\_\_\_\_ If so, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you smoke? If so, what do you smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cigarettes\_\_\_\_\_\_\_\_ Pipe\_\_\_\_\_\_\_\_ Cigars\_\_\_\_\_\_\_\_\_\_

 For how many years have you smoked? \_\_\_\_\_\_\_\_\_ How much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Daily consumption of alcoholic beverages:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future?

 Give details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN** Have you ever been treated for a gynecological complaint? \_\_\_\_YES\_\_\_\_NO If so which and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Department of Human Development, Education and Culture****PHYSICAL EXAMINATION[[1]](#footnote-1)\*****TO BE COMPLETED AND SIGNED BY PHYSICIAN** |
| **NAME OF PATIENT**  (first, middle, last):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**TODAY’S DATE** (mo-day-yr):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_ \_Height : Weight : **Pulse** **Respirations** **Blood Pressure** **Temperature**\_\_\_\_\_\_inches/meters \_\_\_\_\_\_\_pounds/kilograms \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ |
|  Check each item: N: - Normal AN: - Abnormal (describe) O: - Not examined | Note to physician: Describe abnormalities below. Use reverse side if necessary. Describe significant injuries or illnesses since date of last examination. Specify especially any disability or other sequela. Please review applicant’s self-administered Medical History form. |
|  | N | AN | O | Description of Abnormality |
| Eyes/Vision |  |  |  |  |
| Ears/Hearing |  |  |  |  |
| Head/Nose/Sinuses |  |  |  |  |
| Mouth/Throat/Pharynx |  |  |  |  |
| Neck/Thyroid |  |  |  |  |
| Chest/Breasts |  |  |  |  |
| Blood Pressure |  |  |  |  |
| Heart/murmurs/rhythm |  |  |  |  |
| Lungs |  |  |  |  |
| Peripheral Vessels |  |  |  |  |
| Abdomen |  |  |  |  |
|  a) Liver |  |  |  |  |
|  b) Spleen |  |  |  |  |
|  c) Other |  |  |  |  |
| Groin Genitalia (Hernia?) |  |  |  |  |
| Back |  |  |  |  |
| Rectum-Anus |  |  |  |  |
| Prostate |  |  |  |  |
| Lower Extremities |  |  |  |  |
| Joints |  |  |  |  |
| Neurologic |  |  |  |  |
|  a) Sensory |  |  |  |  |
|  b) Motor |  |  |  |  |
|  c) DTR’s |  |  |  |  |
| Skin |  |  |  |  |
| Lymph Nodes |  |  |  |  |
| Has the applicant ever suffered from any nervous or mental disorders? If so, please provide name of condition, duration (specify dates), and final results. |
| After reviewing the applicant’s medical history (pages 1 and 2 of this form) and completing the physical examination, do you consider the applicant to be physically and mentally capable of successfully pursuing and completing a full-time program of study in an academic institution and of adjusting to living overseas? If your answer is NO, please comment reasons why.How would you rate the applicant’s health, mental, and physical condition? Excellent Good Fair Poor  |
| **Tests and Results** BCG vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  PPD Skin Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chest X-Ray if positive + PPD \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EKG (Over 40) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occult Blood Test (Stool) (over 50) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Or family history colon cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **SUMMARY:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s Name (Please Print) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician’s Signature |

1. \* This certificate is valid only for 1 (one) year since the date of physician’s signature. [↑](#footnote-ref-1)