SEINAN GAKUIN UNIVERSITY International Student Medical Report

STUDENT INSTRUCTIONS: EVERY STUDENT enrolling at Seinan Gakuin University is required to a report of his/her medical history and physical examination on this form. The student is to fill in all of the personal data and medical history below.

Name:_____ Date of Birth: ____ /_____/_____ Sex: □Male □Female

Home Institution:_____

Home Address:_____
Street City State Country

Ⅰ. PERSONAL HISTORY (To be filled out by student)

A. IMMUNIZATION HISTORY (please check the boxes if you apply)

Disease	Incidence of Disease/Age (MM/DD/YY)		Titer Test Date/Result (MM/DD/YY)		Vaccine Date Given/Age (MM/DD/YY)	
Measles	□		□		□	① ②
Rubella	□		□		□	① ②
Mumps	□		□		□	① ②
Chicken Pox	□		□		□	
Poliomyelitis	□		□		□	① ② ③

B. CURRENT/PAST HISTORY (please check the boxes if you apply)

	Infected Date/Age (MM/DD/YY)			Infected Date/Age (MM/DD/YY)			Infected Date/Age (MM/DD/YY)	
□	Asthma		□	Diabetes		□	Epilepsy or Convulsions	
□	Tuberculosis		□	Hepatitis		□	High Blood Pressure	
□	Anemia		□	Kidney Disease		□	Bleeding Disorders	
□	Heart Disease		□	Stomach Trouble		□	Bone or Joint Disease	

C. Any past/present serious injuries, surgeries, illnesses or hospitalizations_____

D. Have you ever been under treatment for a mental or emotional illness or depression? Yes_____ No_____

If yes, please specify: _____

E. Have you ever been treated for drug or alcohol abuse? Yes _____ No _____

F. List of any known drug or food allergies:_____ _____

Ⅱ. PHYSICAL EXAMINATION

Note: All the items in this section are required to be filled out completely by physician or health care provider.

A. Height: _____cm Weight: _____kg B. Blood Pressure: _____/_____mmHg

B. Vision Without Glasses: Right_____ Left_____ Corrected: Right_____ Left _____

C. Hearing: Right_____ Left_____

	Yes	No		Yes	No		Yes	No		Yes	No
Development			Posture			Skin			Ears		
Eyes			Nose			Mouth			Tonsils		
Neck			Thyroid			Chest			Heart		
Lungs			Breasts			Abdomen			Upper Extremity		
Lower Extremity			Bone and joints			Feet			Neurologic		
Psychiatric											

If answer is "NO", please indicate:

Name:_____

D. Tuberculosis Control

***Tuberculin Skin Test or TB Blood test is required within 1 year**

***If test is positive, Chest X-ray is required**

a. Tuberculin Skin Test (TST)

Date Given _____ **Date Read** _____

Result _____ **mm of Indurations (Positive > 10mm)**

b. TB Blood Test (Interferon-Gamma Release Assays, IGRAs)

Method: □T-spot or □QFT or □other ( )

Date Obtained _____ **Result: □Negative / □Positive**

c. Chest X-ray (If TST or IGRA is positive)

Date of Examination: _____ **Findings: □Normal / □Abnormal**

□Active TB disease **□No findings of active TB disease**

Comments: _____

E. Current Medications List: (Name/Usage/Dose) (Prescribing Physician/ Over-the-Counter Medications) (Date Began)

_____

_____

_____

F. Activity Limitations: _____

Comments: _____

_____

_____

_____

_____

Signature of Physician: _____ **Date :** _____/_____/_____

Name of Physician: _____

Name and Address of Medical Facility: _____

Phone: _____