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 Address:_____
Street City State Country

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

A. IMMUNIZATION HISTORY (please check and give approximate age)

Disease	Disease Date		Titer Date & Result		Vaccine	
Measles	☐		☐		☐	① ②
Rubella	☐		☐		☐	① ②
Mumps	☐		☐		☐	① ②
Chicken Pox	☐		☐		☐	
Poliomyelitis	☐		☐		☐	① ② ③

B. CURRENT/PAST HISTORY (please check and give approximate age)

☐	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_____

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

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

Ⅱ. PHYSICAL EXAMINATON

Note: all the items in this section are required to be filled out completely by physician or health care provider. Do not return until completed.

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

B. Vision

Without Glasses: Right_____ Left_____ Corrected: Right_____ Left _____

C. Hearing: Right_____ Left_____

Check - normal	Yes	No		Yes	No		Yes	No	If answer is "No", please indicate
Development			Tonsils			Abdomen			
Posture			Neck			Upper Extremity			
Skin			Thyroid			Lower Extremity			
Ears			Chest			Bone and joints			
Eyes			Heart			Feet			
Nose			Lungs			Neurologic			
Mouth			Breasts			Psychiatric			

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: _____