

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	Had Disease	Vaccine	①	②
Measles	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>		<input type="checkbox"/>	
Poliomyelitis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

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

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy or Convulsions
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stomach Trouble	<input type="checkbox"/> 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 EXAMINATION

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

C. Vision

Without Glasses: Right _____ Left _____ Corrected: Right _____ Left _____

D. Hearing: Right _____ Left _____

Check - normal	Yes		No		Yes	No		Yes	No		If answer is "No", please indicate
	Yes	No	Yes	No		Yes	No		Yes	No	
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			

E. Laboratory Results

Urinalysis: Glycosuria_____ Albuminuria_____ Occult blood_____

Remarks_____

Chest X-ray Examination (X-ray taken more than 6 months prior to the certification is NOT valid.)

Findings: Normal / Abnormal

Date of Examination: ___/___/_____

F. Current medications list: (Name/Usage/Dose) (Prescribing Physician/ Over-the-Counter Medications) (Date Began)

G. Activity limitations: _____

Comments: _____

Signature of physician: _____ Date: ___/___/_____

Name of physician: _____

Name and Address of Medical Facility: _____

Phone: _____