<Form 1>

**PERSONAL MEDICAL ASSESSMENT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | |  | | | **Home Univ** | | |  |  |
| Gender: |  | **HEIGHT** |  | cm | **WEIGHT** | | |  | kg |
| 1. When and for what reason did you last consult a physician? (Please explain in the adjacent space.) | | | | |  | | | | |
| QUESTION | | | | | YES | NO | IF ***YES***, PLEASE EXPLAIN | | |
| ② Have you ever had an infectious disease that posed a risk to public health (**such as, but not limited to,** **tuberculosis, HIV and other STDs**)? | | | | |  |  |  | | |
| ③ 1. allergies?  2. high blood pressure?  3. diabetes?  4. any type **of Hepatitis**? | | | | |  |  |
|  |  |
|  |  |
|  |  |
| ④ Have you ever suffered from or been treated for depression, anxiety, or any other mental or mood disorder? (If you have received treatment, please explain and attach an official medical report.) | | | | |  |  |
| ⑤ Have you ever been addicted to alcohol? | | | | |  |  |
| ⑥ Have you ever abused any narcotic, stimulant, hallucinogen or other substance (whether legal or prohibited)? | | | | |  |  |
| ⑦ Have you been hospitalized in the last two (2) years? | | | | |  |  |
| ⑧ Have you had any serious injury, ailment or sickness in the last five (5) years? | | | | |  |  |
| ⑨ Do you have any visual or hearing impairments? | | | | |  |  |
| ⑩ Do you have any physical disabilities? | | | | |  |  |
| ⑪ Do you have any cognitive/mental disabilities? | | | | |  |  |
| ⑫ Are you taking any prescribed medication? | | | | |  |  |
| ⑬ Are you on a special diet? | | | | |  |  |
| ⑭ On average, how many standard servings of alcohol do you consume each week? | | | | | | |  | | |
| QUESTION | | | | | YES | NO | IF ***NO***, PLEASE EXPLAIN | | |
| ⑮ If necessary, are you prepared to undergo physical tests to verify the answers given in response to questions above? | | | | |  |  |  | | |

The answers I have given above are true and correct to the best of my knowledge. If my answers contain any kind of falsehood, I will take any legal responsibility.

Date(yyyy/mm/dd): . . .

NAME OF THE APPLICANT SIGNATURE OF THE APPLICANT

<Form 2>

**OFFICIAL MEDIACL EXAMINATION**

**1. Personal Information**

Full Name:

Gender:

Date of Birth:

Nationality:

Home University:

**2. Chest X‐ray Examination**

UNI000001dc0451 Date taken:

\* For student who wants to stay at on-campus housing, the x-ray should be taken within 3 months before check-in dates.

You can submitted this result later than the application period.

UNI000001dc0453 Findings:

UNI000001dc0453Tuberculosis: Yes( ), No ( )

**3. Others**

|  |  |  |
| --- | --- | --- |
| **Date of Vaccination** | **Hepatitis A** | **MMR** |
| **1st** | (MM/DD/YY) | (MM/DD/YY) |
| **2nd** | (MM/DD/YY) | (MM/DD/YY) |
| **memo** |  |  |

Hemoglobin: Gm/dl

Urine: S.G. Sugar Micro

UNI000001dc0455Hepatitis B:

UNI000001dc0457Stool for Parasite Oval:

UNI000001dc0459Serological Test for Syphilis & AIDS:

Other:

In my opinion his/her health condition is;

Excellent ( ) Good ( ) Fair ( ) Poor ( )

This is to certify that the above named applicant has gone through a general medical examination and the findings indicated here are true to the best of my knowledge.

|  |  |  |  |
| --- | --- | --- | --- |
| Date |  |  | Hospital and Contact Information |
| M.D |  |  |
| Signature |  |