GLOBAL STUDY CONNECTIONS

Live Your Dream - Study Abroad!

Health & Medical Record Questionnaire

STUDENT INFORMATION

Student's Name: _____ Birthdate: _____

Address: _____ Gender: ☐ Male ☐ Female

City: _____ Country: _____

Telephone: _____ Email: _____

DOCTOR INFORMATION

Doctor's Name: _____

Address: _____

City: _____ Country: _____

Telephone: _____

MEDICAL HISTORY

Have you had? Check all that apply.

☐ Measles	☐ Rheumatic fever or heart disease	☐ Sexually transmitted disease
☐ Mumps	☐ Concussion or head injuries	☐ Strokes
☐ Chickenpox (varicella)	☐ Diabetes	☐ Tuberculosis
☐ Epilepsy	☐ Cancer	☐ Broken bones
☐ Hepatitis	☐ Other communicable diseases	

Have you ever been hospitalized, had surgery, or been under extended Medical care? No ☐ Yes ☐

If yes, for what reason? _____

SYSTEMIC OVERVIEW & HISTORY

Do you have the following? Check all that apply.

☐ Eye disease or injury	☐ Hearing aids	☐ Ear disease	☐ Nosebleeds
☐ Headaches	☐ Eyeglasses	☐ Dizziness	☐ Impaired hearing
☐ Chronic sinus trouble	☐ Glaucoma	☐ Double vision	☐ Episodes of unconsciousness

Skin:

☐ Abnormal pigmentation	☐ Jaundice	☐ Frequent infection or boils
☐ Skin disease, hives, eczema		

Neck:

☐ Stiffness	☐ Thyroid trouble	☐ Enlarged glands

Respiratory:

☐ Spitting up blood	☐ Asthma	☐ Chronic or frequent cough

Have you been in good general health most of your life? No ☐ Yes ☐

If no, please explain. _____

ALLERGIES and SENSITIVITIES

Is there a history of skin reaction or other reaction or sickness following injections, topical applications or oral administration of:

□ Penicillin or other antibiotics
□ Morphine, codeine, Demerol, other narcotics
□ Aspirin, Empirin or other pain remedies
□ Tetanus, antitoxin or other serums
□ Any foods, such as egg, milk or chocolate
□ Novocaine or other anesthetics
□ Sulfa drugs
□ Adhesive tape or latex (circle)
□ Iodine or merthiolate
□ Any other drug or medication
□ Any topical applications

List: _____
_____
_____
_____

List: _____
_____
_____

Pet/animal allergies? No □ Yes □
If yes, please explain. _____
_____
_____
_____

Other allergies? No □ Yes □
If yes, please explain. _____
_____
_____
_____

MENTAL HEALTH

Have you ever received any medical attention or counseling for psychological or emotional issues?
No □ Yes □

If yes, please explain. _____

_____

Have you ever received pharmacological treatment (medication) for a psychological or emotional issue?
No □ Yes □

If yes, please explain. _____

_____

MEDICATIONS

Are you currently taking medications for any reason? No □ Yes □

If yes, please list. _____

_____

_____

We certify that the information supplied is true and complete to the best of our knowledge. We authorize any of the doctors, hospitals, or clinics mentioned above to furnish a complete transcript of medical records for purposes of processing this application. Undisclosed information or inaccuracies in information provided could result in dismissal from John Bapst.

Signature of Student: _____ Date: _____

Signature of Parent: _____ Date: _____