Medical Form

Please complete this form and return it with your application forms.

Print Clearly!

Personal Medical History

Name: Date of Birth:

Sex: ☐ Male ☐ Female Height: Weight:

Current Marital Status: Wählen Sie ein Element aus.

Please tick the immunization you had:

☐ Mumps	☐ Rubella	☐ Smallpox	☐ BCG Vac
☐ Polio	☐ Cholera	☐ Tetanus	☐ Hepatitis B
☐ Influenza	☐ Diphteria	☐ Typhus	☐ Hepatitis A
☐ Pertusis	☐ Measles	☐ Typhoid	☐ Yellow Fever

Indicate by ticking whether you have had the following and they still apply to you now. If so, please explain afterwards.

☐ Asthma	☐ Thyroid Trouble	☐ Cancer	☐ Convulsions
☐ Epilepsy	☐ Leukemia	☐ Hepatitis	☐ Venereal Disease
☐ Hypoglycemia	☐ Bulimia	☐ Anorexia Nervosa	☐ Drug Flashback
☐ Diabetes	☐ Tuberculosis	☐ Stomach Ulcers	☐ Excessive fatigue
☐ Back Problems	☐ Rheumatic Fever	☐ Psychiatric Counseling	☐ severe headaches

☐ Physical disabilities/handicaps ☐ High Blood Pressure ☐ Fainting spells

☐ Anemia ☐ Homesickness

Explanation

What is your blood group? (very important):

Do you require a special diet? If so, give details.

Questions

Are you presently taking any medication? If so, give name of medication, dosage and reason for taking medication.

Specify if you have any allergies (to a medication or other):

Is there any possibility that you may have AIDS or been exposed to the AIDS virus? Explain.

Have you ever had a prolonged period (months) of depression / treatment?

Please give details and dates of any nervous breakdowns or mental illness.

Do you suffer from wakefulness / difficulty in falling asleep, or disturbed sleep?

Have you ever been addicted to drugs or alcohol? Wählen Sie ein Element aus.

If yes, what is your present condition?:

Have you ever suffered from a phobia (persistent irrational fear)? Wählen Sie ein Element aus.

If yes, please specify:

Emotional History

Do you have any lack of emotional control or unusually sensitive?

Have you ever received treatment or counseling by a professional or non-professional

person for psychological or emotional problems? Wählen Sie ein Element aus.

If yes, please explain:

Have you ever lived abroad (include study at school, college, university)? Wählen Sie ein Element aus.

If yes, where and for how long?

How did you cope?

☐ Well ☐ Reasonably well ☐ Not well

Did you suffer from illness there? Wählen Sie ein Element aus.

If yes, please give details:

I certify that I have answered the above questions fully an honestly and that I have no other significant health problems.

Date: Signed: