Alliance Graduate School

MEDICAL FORM

It is in the applicant's own interest to complete this form as honestly and as accurately as possible. Please type or print legibly all information.

Portion to be completed by the applicant:

Full name _____ Date of Birth _____

Sex _____ Status _____ Number and ages of children _____

Family History. List illnesses or causes of death of the following:

Parents : _____

Brothers / Sisters : _____

Spouse and Children : _____

_____

Signed _____ Date Signed _____

Portion to be completed by the applicant's doctor:

Medical history of the Applicant

1. Does he / she have any physical deformities or limitations? If so, please specify.
   _____
   _____

2. If he / she suffers from any of the following, please underline:

Poor vision	Allergies	Frequent diarrhea
Eye strain	Shortness of breath	Frequent Constipation
Poor hearing	Asthma	Muscle or bone pain
Noises in ear	Bronchitis	Insomnia
Frequent headaches	Palpitation of the heart	Frequent urination
Nose bleeds	Food intolerance	Dysmenorrheal
Bleeding gums	Indigestion	

List any illness he / she had (including surgery, diabetes, heart trouble, seizures, venereal disease, and tuberculosis) _____

Is he / she allergic to any drug? _____ If so, which? _____

Is he / she taking long-term drugs? _____ Which? _____

Examination of the applicant

Eyes: Visual acuity – Right _____ Left _____

Ears: Hearing - Right _____ Left _____

Mouth _____ Throat _____

Teeth _____ Palpable glands _____

Chest: Expansion _____ Auscultation _____

Cardio-Vascular System: Pulse (resting) _____ After 1 min. running _____

Blood pressure Heart Sounds _____

Abdomen: Scars? _____ Palpable organs? _____

Tenderness _____ Hernias? _____

Genitalia _____ Rectum _____ Hemorrhoids _____

Mental Evaluation

Has the applicant any history of mental disorder? _____ If so, state its duration and treatment given:

_____

_____

Is there now any sign of excess anxiety, depression, or hallucination? _____

_____

Laboratory Tests

Chest X-ray (or screen) _____

Blood type _____

IMPORTANT: Do you find from the applicant's history and examination reasons to think he / she might not tolerate intensive study, changes of diet, climate and culture?

_____

_____

Please summarize important findings:

_____

_____

_____

Doctor's Signature (over printed name): _____

Address _____

Contact no(s). _____