ACTS College 学院

Accredited by the Asia Theological Association and the Asia Pacific Theological Association
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MEDICAL EXAMINATION FORM

(To be submitted with the Application of Admission Form)

Name: ____

Sex: [Male / Female] Date of Birth (dd/mm/yy): _______/_______/_______

Height (m): __________ Weight (kg): __________

Marital Status: [Single / Married / Divorced / Widowed / Others __________________________]

1. MEDICAL HISTORY

Past illnesses:

[ ] Allergies [ ] Asthma [ ] Diabetes

[ ] Menstrual cramps [ ] Epilepsy [ ] Hepatitis

[ ] High blood pressure [ ] Kidney disorder [ ] Migraine

[ ] Sinusitis [ ] Skin problem [ ] Tuberculosis

Past operations, accidents, injuries: ____

Medications: ____

Smoking: ___________________ Alcohol: _____________ Drug addiction: _________

Family history: ____

Social/psychiatric history: ____

2. GENERAL CONDITION

Ears: ___________________________________ Eyes: ___________________________

Skin: ____

Breasts (for female students): ____

Other remarks: ____

____

3. CARDIO-VASCULAR SYSTEM

Heart: ___________________________________

Pulse: ___________________________________

Blood pressure: ____________________________

Varicose Veins: ____________________________

4. GLANDS

____

____

Updated on 6 May 2016

5. **RESPIRATORY SYSTEM**
Nose: ________________________________

Lungs: ________________________________ Chest X-ray: ______________________

6. **ALIMENTARY SYSTEM**

Mouth & Pharynx: ______________________ Teeth: __________________________

Abdomen: ____________________________

7. **URINARY SYSTEM**

Urinalysis protein / glucose: ____

8. **NERVOUS SYSTEM**

____

____

9. **OTHERS**

HBs Antigen: ___________________________ Antibodies: ______________________

VDRL and HIV: ____

BF for Malaria Parasites: ____

10. **GENERAL REMARKS**

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____

I certify that ____ has been examined by me and has no significant physical or mental illness that will adversely affect his/her studies at ACTS COLLEGE.

I should advise that special care be given for his / her ________________________________.

____
Signature of Examining Doctor / Date

Name : _____________________________________

Clinic : _____________________________________

Address: _____________________________________

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Contact: _____________________________________