ASIA GRADUATE SCHOOL OF THEOLOGY-PHILIPPINES

Hosted by the **International Graduate School of Leadership (IGSL)**

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D.Min./Th.M.-Ph.D. in Peace Studies

MEDICAL FORM

(It is in the applicant's own interest to complete this form as honestly and as accurately as possible.
If the applicant is accepted into the program, this form will be on file for reference in case of a medical emergency.)

Please type or print all information legibly.

PORTION TO BE COMPLETED BY APPLICANT:

Full Name _____ Date of Birth _____

Sex _____ Single/Married _____ Number and ages of children _____

Home Address _____

_____

In case of Emergency, contact (give name, relation to you, contact info):

Name Relationship Contact information (cell or phone, email)

_____

_____

Family History: List major illnesses and/or causes of death of . . .

Parents: _____

Brothers or Sisters: _____

Wife or children _____

Signed: _____ Date: _____

PORTION TO BE COMPLETED BY APPLICANT'S DOCTOR:

1. How long have you known or treated this person? _____
2. Is he/she allergic to any drugs? ____ If so, which? _____
3. If he/she suffers from any of the following, please encircle them:

Poor vision	Allergies	Diarrhea
Eye strain	Shortness of breath	Frequent constipation
Poor hearing	Asthma	Muscle or bone pain
Noises in ears	Bronchitis	Mental/emotional depression
Frequent headaches	Palpitations of the heart	Sleep trouble
Frequent colds, cough	Skin disease	Frequent urination
Nose bleeds	Food intolerance	Blood in urine or stool
Bleeding gums	Indigestion	Trouble with periods (if female)
Sinus trouble	Stomach pains	Chronic pain or fatigue

4. List major illnesses he/she has had, length of time (e.g., diabetes, heart trouble, seizures, surgeries)

5. If he/she is taking on going medicines, specify purpose and meds: _____

6. Does he/she have any physical limitations at all? (If so, please specify)

Examination of applicant: Height _____ Weight_____ Blood Pressure _____

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. exercise _____
Blood Pressure _____ Heart sounds _____
Abdomen: Scars _____ Palpable organs _____
Tenderness _____ Hernias _____
Hemorrhoids _____ Other _____
Neurological: Power _____ Sensation _____
Co-ordination _____ Reflexes _____

Mental/Emotional Evaluation: Has the applicant any history of mental/emotional disorder? ___ If so, what? _____
Describe symptoms, state duration and treatment. _____
Are there currently any signs of excessive anxiety, any depression or emotional disturbance? ____ If so, please describe:

Laboratory tests: Chest X-ray (or screening) _____
Blood tests _____

Please summarize important findings:

IMPORTANT: Do you find from the applicant's history and examination any reasons to think he/she might not tolerate years of intensive mental and emotional demands, travel, and changes of diet, climate and culture? _____ If so, please explain:

Date: _____ Signature of Doctor: _____

Printed Name of Doctor: _____

Are you the applicant's primary care physician? ___ Yes ___ No May we contact you in case of an emergency? ___ Yes ___ No

Address: _____

_____

Office Phone: _____ Cell Phone: _____