REVISED 12.13

International Student

HEALTH RECORD FORM

To the examining physician:

Please review the student's history and complete the information requested on this side of the form. Please comment on all abnormalities to which you answered yes. The reverse side of the form is to be completed by the student. The information furnished will be used only as a background for providing health care if it is necessary. Observe carefully the requirements for TB Test and other immunizations.

PLEASE TYPE OR PRINT IN INK AND RETURN TO:
Freed-Hardeman University
Office of Admissions
158 E. Main Street, Henderson, TN 38340-2398
Fax: 731.989.6047

Student's Name_____
Last First Middle

Sex _____ Citizenship _____

Please do not return this form until the result of the Tuberculin Skin Test is recorded. Test must be administered within the past 12 months. Results:_____mm induration Date of BCG vaccine _____

IMMUNIZATION REQUIRED TENNESSEE STATE LAW	DATE OF FIRST INJECTION MONTH/DAY/YEAR	DATE OF SECOND INJECTION MONTH/DAY/YEAR
Rubella	_____ /_____ /_____	_____ /_____ /_____
Measles	_____ /_____ /_____	_____ /_____ /_____
Mumps	_____ /_____ /_____	_____ /_____ /_____

Are there any abnormalities of the following systems? If so, describe.

- ❑ YES ❑ NO Head, ears, nose or throat
- ❑ YES ❑ NO Respiratory
- ❑ YES ❑ NO Cardiovascular
- ❑ YES ❑ NO Gastrointestinal
- ❑ YES ❑ NO Hernia
- ❑ YES ❑ NO Eyes
- ❑ YES ❑ NO Genitourinary
- ❑ YES ❑ NO Musculoskeletal
- ❑ YES ❑ NO Metabolic/Endocrine
- ❑ YES ❑ NO Neuropsychiatric
- ❑ YES ❑ NO Skin
- ❑ YES ❑ NO Any loss of or impaired function of any paired organ
- ❑ YES ❑ NO Limited physical activity (P.E. or intramurals)
- ❑ YES ❑ NO Is the patient now under treatment for any medical or emotional condition? (If yes, describe)
- ❑ YES ❑ NO Any general comments or recommendations regarding the care of this student? (If yes, describe) _____
_____
_____
_____

Physician's Signature _____ Print last name:_____

Address _____Date _____

Information on this side of the form is to be supplied by the student.

Name _____
LAST FIRST MIDDLE

Address _____ Date of Birth _____

City _____

State _____ Zip _____ Country _____

Next of kin _____ Relationship _____ Home Phone _____

Address of next of kin _____ Business Phone _____

Name of Medical Insurance _____ Policy Number _____

Colleges you have attended: ADDRESS DATES

_____

_____

_____

Please answer all the following questions regarding your family history to the best of your knowledge.

RELATION	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers (#, Age)					
Sisters (#, Age)					

Have any of your relatives had any of the following? If so, list relationship.

- ❑ YES ❑ NO Tuberculosis _____
- ❑ YES ❑ NO Diabetes _____
- ❑ YES ❑ NO Kidney disease _____
- ❑ YES ❑ NO Heart disease _____
- ❑ YES ❑ NO Arthritis _____
- ❑ YES ❑ NO Stomach disease _____
- ❑ YES ❑ NO Asthma _____
- ❑ YES ❑ NO Epilepsy, convulsions _____

❑ YES ❑ NO Are you taking any medications for an illness or condition? If so, what? _____

❑ YES ❑ NO Has your physical activity been restricted during the past five years? Give reasons and durations. _____

❑ YES ❑ NO Have you had difficulty with school, studies or teachers? Give details. _____

❑ YES ❑ NO Have you received treatment or counseling for a nervous condition or emotional problems? Give details. _____

❑ YES ❑ NO Have you visited physicians or other professionals in the past five years for other than routine checkups? Give details. _____

❑ YES ❑ NO Have you been barred or discharged from the military because of physical, emotional or other reasons? Give details. _____

MEDICAL HISTORY

- ❑ YES ❑ NO Scarlet Fever
- ❑ YES ❑ NO Measles
- ❑ YES ❑ NO German Measles
- ❑ YES ❑ NO Mumps
- ❑ YES ❑ NO Chicken Pox
- ❑ YES ❑ NO Malaria
- ❑ YES ❑ NO Sinusitis
- ❑ YES ❑ NO Gum or tooth trouble
- ❑ YES ❑ NO Eye trouble
- ❑ YES ❑ NO Ear, nose, throat trouble
- ❑ YES ❑ NO Insomnia
- ❑ YES ❑ NO Frequent anxiety
- ❑ YES ❑ NO Frequent depression
- ❑ YES ❑ NO Worry or nervousness
- ❑ YES ❑ NO Recurrent headache
- ❑ YES ❑ NO Recurrent colds
- ❑ YES ❑ NO Head injury with unconsciousness
- ❑ YES ❑ NO Hay fever, asthma
- ❑ YES ❑ NO Tuberculosis
- ❑ YES ❑ NO Shortness of breath
- ❑ YES ❑ NO Pain/pressure in chest
- ❑ YES ❑ NO Chronic cough
- ❑ YES ❑ NO Heart palpitations
- ❑ YES ❑ NO High/low blood pressure
- ❑ YES ❑ NO Rheumatic fever or heart murmur
- ❑ YES ❑ NO Disease or injury of joint
- ❑ YES ❑ NO Trick knee/shoulder
- ❑ YES ❑ NO Back problems
- ❑ YES ❑ NO Stomach or intestinal trouble
- ❑ YES ❑ NO Tumor, cancer, cyst
- ❑ YES ❑ NO Jaundice
- ❑ YES ❑ NO Gallbladder trouble
- ❑ YES ❑ NO Gallstones
- ❑ YES ❑ NO Diabetes
- ❑ YES ❑ NO Epilepsy
- ❑ YES ❑ NO Recent weight gain/loss
- ❑ YES ❑ NO Dizziness, fainting
- ❑ YES ❑ NO Venereal disease
- ❑ YES ❑ NO Albumin/sugar in urine
- ❑ YES ❑ NO Frequent urination
- ❑ YES ❑ NO Seizures

FOR FEMALES ONLY

- ❑ YES ❑ NO Irregular periods
- ❑ YES ❑ NO Severe cramps
- ❑ YES ❑ NO Excessive flow

SURGERY FOR

- ❑ YES ❑ NO Appendectomy
- ❑ YES ❑ NO Tonsillectomy
- ❑ YES ❑ NO Hernia repair

ALLERGY

- ❑ YES ❑ NO Penicillin
- ❑ YES ❑ NO Sulfonamides
- ❑ YES ❑ NO Serum
- ❑ YES ❑ NO Foods. If yes, which ones?

_____

_____

❑ YES ❑ NO Other _____

_____

_____

Student's Signature _____ Physician's Signature *(acknowledging review)* _____