Student's Name

CONFIDENTIAL

Health Form

Please return completed form to the

Rector

Seminary of Christ the King

PO Box 3310

Mission, British Columbia

V2V 4J5

This information is strictly confidential for the use of the Rector and Admissions and Evaluation Personnel

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS PAGE BEFORE GOING TO THE PHYSICIAN FOR EXAMINATION

LAST NAME (Print) **FIRST NAME** **MIDDLE** **DATE OF BIRTH** **HOME TELEPHONE**

HOME ADDRESS (Number and street) **CITY OR TOWN** **PROVINCE** **POSTAL CODE**

FAMILY HISTORY

	Age	State of Health	Occupation	Age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives had any of the following			
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			
Alcoholism			

PERSONAL·HISTORY: Please answer all questions. Comment on all positive answers in space below

	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Insomnia			Palpitations (Heart)			Dizziness, Fainting		
Measles			Frequent Depression			High or Low Blood			Weakness, Paralysis		
German Measles			Worry or Nervousness			Pressure			Venereal Disease		
Mumps			Recurrent Headache			Rheumatic Fever or Heart Murmur			Albumin/Sugar in Urine		
Chicken Pox			Head Injury with unconsciousness								
Malaria						Disease/Injury of Joints			Frequent Urination		
Gum/ Tooth Trouble			Hay Fever, Asthma			"Trick" Knee, Shoulder			Shortness of Breath		
Sinusitis			Tuberculosis			Back Problems			Recurrent Colds		
Eye Trouble			Allergy			Tumor, Cancer, Cyst			Chronic Cough		
Ear Trouble			Penicillin			Jaundice			Night Sweats		
Nose Trouble			Sulfonamides			Stomach Trouble			Swelling of Glands		
Throat Trouble			Serum			Intestinal Trouble			Skin Rash		
Appendectomy			Foods (Which?)			Gallbladder Trouble			Recurrent Diarrhea		
Tonsillectomy			Other			Gallstones			Other		
Hernia Repair			Pain/Pressure in Chest			Rupture, Hernia					
Other Surgery						Recent Gain or Loss of Weight					

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and		
B. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)		
C. Have you had any illness or injury or been hospitalized other than already noted?		
D. Have you ever had any serious mental illness?		
E. Has there been any serious mental illness in your family?		
F. Have you any habits detrimental to your health such as smoking, alcohol, or drugs?		
G. Are you an alcoholic?		
H. Have you ever used intravenous or injectable drugs		
I. Have you consulted or been treated by clinics, physicians, healers or other practitioners within the past five years? (Other than routine check ups?)		
J. Do you have any questions in regard to your health, family history, or other matters which you would like to discuss?		
K. Have you had sexual contact with another male or with a prostitute in the past seven years?		

To add remarks or additional information, use back page.

I hereby certify that the above information is true and complete.

Student 's Signature

Date

Physician's Signature (Acknowledging Review) Date

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. This information is strictly confidential for the use of the Rector and the Admission and Evaluation personnel.

BP:

Height: Weight:

Corrected Vision: Overweight: Underweight:

Right20/ Left/20 Tuberculin Skin Test: Positive: Negative:

Urinalysis		Immunization	Completed		Date of last injection	
Sugar:						
Albumin:			Yes	No		
Micro:		Required				
If Indicated:		Tetanus within 10 yrs				
HIV		Recommended				
VDRL		Polio				
HEPB SER.		Diptheria				

Are there abnormalities of the following systems? Describe fully. Use back page if necessary.

	Yes	**No**		**Yes**	**No**
1. Head, Ears, Nose, Throat			7. Genitourinary		
2. Respiratory			8. Musculoskeletal		
3. Cardiovascular			9. Metabolic/Endocrine		
4. Gastrointestinal			10. Neuropsychiatric		
5. Hernia			11. Skin		
6. Eyes					

Is there loss or seriously impaired function of any paired organ? Yes: ____ No: ____

Have you any general comments?

Recommendations for physical activity (PE, Intramurals): Unlimited: _____ Limited: _____ If limited, please explain:

Do you have any recommendations regarding the care of this student? Yes: ____ No: ____

Is this student now under treatment for any medical or emotional conditions? Yes: ____ No: ____

PHYSICIAN'S SIGNATURE: _____ DATE: _____

ADDRESS: _____

PLEASE PRINT NAME: _____

Additional Information or Remarks