Health Check Form (for applicants)

General Information

Name

Sex □ Male □ Female

Date of Birth Year: Month: Day:

Blood type ABO: Rh: □ Not sure

Illness and Surgical History

Please select any illnesses you have had.

□ Chicken Pox □ Measles □ Mumps

□ Rubella □ Hernia □ Herpes

□ High blood pressure □ Kidney disease □ Convulsions or Epilepsy

□ Diabetes □ Liver disease □ Tuberculosis

□ Heart disease □ Thyroid problem □ Hepatitis

□ Cerebrovascular disease □ Asthmatic bronchitis □ HIV

□ Malaria □ Other (please specify)

Have you had any operations before?

□ No □ Yes: What?

Have you had a blood transfusion?

□ No □ Yes: What was it for?

Do you tend to bleed much? □ No □ Yes □ Not sure

Allergies

Have you ever been allergic to anything? (medicine, food, other)

□ No □ Yes: What?

Have you had side effects caused by medicine?

□ No □ Yes: Which medicine?

Have you had problem after having a local or general anesthetic?

□ No □ Yes: What?

Questions for Women

Are you pregnant? □ No □ Yes □ Not sure

Are you currently breasted? □ No □ Yes

Are you taking contraceptive pills? □ No □ Yes

Medication

Are you currently taking any prescribed or over-the-counter medicine(s)?

□ No □ Yes: Which medicine?

Why are you taking it / them?

Date 　　/ /2018 Signature