OFFICE OF ADMISSIONS
INTERNATIONAL GRADUATE SCHOOL OF LEADERSHIP

MEDICAL HISTORY & LABORATORY EXAMINATION

Applicant: As part of your application process, it is necessary for you (and your spouse and child/ren, if married) to complete this history. Please ensure that the information is **complete** and **accurate**.

Name: _____ Age: _____ Birthdate: _____
Sex: _____ Nationality: _____ Date when form was filled up: _____

I. HAS ANY *BLOOD RELATIVE* HAD ANY OF THE FOLLOWING? Check [✓] the appropriate box.

Yes	No		Relation	Yes	No		Relation	Yes	No		Relation
		Tuberculosis				Diabetes				Arthritis, Rheumatism	
		Glaucoma				Kidney Trouble				Asthma, Hives, Hay Fever	
		Cancer				Migraine Headaches				Epilepsy	
(list type of cancer)						High Blood Pressure				Committed Suicide	

II. HAVE YOU EVER HAD, BEEN TREATED FOR, OR CONSULTED A PHYSICIAN FOR THE FOLLOWING PROBLEMS? Check [✓] the appropriate box. Give full details for each "Yes" answer in section III at the bottom of this page. Add an extra page if needed.

Yes	No		Yes	No		Yes	No	
		Heart Trouble			Digestive Disorder			Tumor
		Heart Murmur			Intestinal Disorder			Cyst
		Rheumatic Fever			Hepatitis			Skin Disorder
		Chest Pain			Cirrhosis			Recurring Allergy
		Stroke			Other Liver Trouble			Hernia
		High Blood Pressure			Kidney Stone or Infection			Hemorrhoids
		Abnormal Pulse			Bladder Stone or Infection			Varicose Veins
		Hardening of the Arteries			Prostate Trouble			Circulatory Disorder
		Diabetes			Sugar, Albumin, Blood or Pus in Urine			Arthritis
		Thyroid or Other Gland Problem			Psychiatric Problem			Rheumatism
		Blood Disorder			Emotional Problem			Sciatica (acute pain in the hip and thigh due to sciatic nerve)
		Asthma			Nervous Problem			Gout
		Bronchitis			Epilepsy			Deformity
		Tuberculosis			Convulsion			Amputation
		Other Lung Disorder			Dizziness			Disease of Eyes
		Ulcer			Loss of Consciousness			Disease of Ears
		Gall Bladder Disease			Frequent Headaches			Disease of Nose
		Colitis			Other Nervous System Disorder			Disease of Throat
		Internal Bleeding			Cancer			

FULL DETAILS FOR EACH "YES:" Identify each problem listed above, describing the nature and severity of the condition. Include frequency, treatment, medication, surgery, results, onset year, and recovery year.	Onset Year	Recovery Year

III. HAVE YOU EVER HAD THE FOLLOWING? Check [✓] the appropriate box. Give full details for each "Yes" answer in section V at the bottom of the page. Add an additional page if needed.

Yes	No		Yes	No		Yes	No	
		General:			Breasts:			Genital/Urinary System: (Cont'd)
		Tire easily, weakness			Soreness			Increase in frequency of urination (night)
		Marked weight loss			Lumps			Feel need to urinate without much Urine
		Night Sweats			Discharge			Inability to hold urine
		Persistent Fever			Cardio-Respiratory System:			Pain or burning
		Advice or treatment for use of alcohol or narcotics			Cough, persisting			Blood in urine
		other drugs (LSD)			Sputum (phlegm)			Lack of sex drive
		Do you smoke?			Bloody sputum			Menstrual disorder
		Frequent use of any medication			Wheezing			Disabling, painful menses
		Any hospitalizations?			Chest pain or discomfort			Pregnancy
		Any surgery?			Pain on breathing			Abortion/Miscarriage
		Skin:			Shortness of breath			Endocrine: (Glands)
		Eruptions (rash)			Difficulty breathing while lying down			Thyroid trouble
		Eyes:			Swelling of ankles			Adrenal trouble
		Trouble seeing			Bluish fingers or lips			Cortisone treatment
		Eye pain			High blood pressures			Diabetes
		Inflamed eyes			Palpitations			Hypoglycemia
		Double vision			Vein trouble			Muscle/Joint System:
		Need for glasses			Digestive system:			Muscle cramps
		Ears:			Belching or excess gas			Muscle spasms
		Loss of hearing			Change in appetite			Muscle weakness
		Ringing in ears			Difficulty in swallowing			Pain in joints
		Discharge			Heartburn			Swollen joints
		Nose:			Abdominal distress			Stiffness
		Loss of smell			Abdominal enlargement			Heat in joints
		Frequent colds			Nausea			Nervous system:
		Obstruction			Vomiting			Headaches
		Excess of discharge			Vomiting of blood			Dizziness
		Nosebleeds			Rectal bleeding			Fainting
		Mouth:			Tarry stools			Convulsions or fits
		Sore gums			Jaundice			Nervousness
		Soreness of tongue			Constipation			Sleeplessness
		Dental Problems			Diarrhea			Depression
		Throat:			Hemorrhoids			Memory loss
		Post-nasal drainage			Need for laxatives			Poor coordination
		Soreness			Genital/Urinary system:			Weakness or paralysis of muscles
		Hoarseness			Increase in frequency of urination (day)			

FULL DETAILS FOR EACH "YES:" Identify each problem listed above, describing the nature and severity of the condition. Include frequency, treatment, medication, surgery, results, onset year and recovery year.	Onset Year	Recovery Year

MEDICAL HISTORY & LABORATORY EXAMINATION

PHYSICAL EXAMINATION

This portion should be accomplished by a licensed physician. Complete your medical history form AND have your laboratory tests done first *before* going to the doctor for your medical examination. Show both your medical history and laboratory reports to the doctor then have him or her fill up this medical examination form.

Date of exam: _____	Build: (circle)		BP: _____	Any extra systoles? ____
Measurements:	underweight	heavy	Pulse at rest: _____	Any arrhythmia? ____
Ht: _____ ft _____ in	medium	obese	Pulse after exercise: _____	
Wt: _____ kg			Pulse 5 minutes later: _____	

Please examine and check (✓) each area:

	Normal	Abnormal
Ears:		
Eyes:		
Nose:		
Throat:		
Neck:		
Breasts:		
Heart:		
Lungs:		
Abdomen:		
Genitalia:		
Pelvic (Pap smear required for female 35 years above):		
Rectal (required):		
Extremities:		
Spine:		
Skin:		
Glands:		

LABORATORY EXAMINATION

1. **Preliminary lab exam**

   Complete blood count
   Chest X-ray
   Fecalysis
   Urinalysis

   Comments:

2. **Additional for male/female 40 years old and above:**

   Basic blood chem exam
   BUN, Crea, BUA, FBS
   Total Chole, HDL, LDL, Triglycerides
   SGOT, SGPT

   Comments:

3. **For patients with history of hypertension or diabetes regardless of age:**

   Blood chems
   FBS, HBA 1C
   Total chole, HDL, LDL, Triglycerides
   BUN, Crea
   SGPT

   Comments:

NOTE TO THE PHYSICIAN:

Kindly indicate the medications of patients with maintenance medications. Include the length of use.

IMPORTANT REMINDER TO THE APPLICANT:

1. Please attach original copies of recent laboratory reports. Do not send x-ray film.
2. If the original laboratory reports are in a language other than English, provide a translation in English. Submit the translation along with the original laboratory reports.
3. For children: Please attach a photocopy of your child's immunization/vaccination record. If none, we will immunize them when you get here.

_____ _____

PHYSICIAN'S SIGNATURE OVER PRINTED NAME DATE