



ASIA GRADUATE SCHOOL OF THEOLOGY-PHILIPPINES

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

(formerly named the International School of Theology - Asia)

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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 _____

Gender _____ 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

Eye strain

Poor hearing

Noises in ears

Frequent headaches

Frequent colds, cough

Nose bleeds

Bleeding gums

Sinus trouble

Allergies

Shortness of breath

Asthma

Bronchitis

Palpitations of the heart

Skin disease

Food intolerance

Indigestion

Stomach pains

Diarrhea

Frequent constipation

Muscle or bone pain

Mental/emotional depression

Sleep trouble

Frequent urination

Blood in urine or stool

Trouble with periods (if female)

Chronic pain or fatigue

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

5. If he/she is taking long-term medicines (e.g. for TB)? If so specify: _____

6. Does he/she have any physical deformities or limitations? (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, depression, or delusion? ___ 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, 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: _____