

**OVERSEAS THEOLOGICAL SEMINARY**  
**Student Health History**  
**海外神學院**  
**學生健康資料**

1. Name of applicant: \_\_\_\_\_ ,  
Last Name                      First Name                      Middle Name                      Chinese Name

2. Name of physician: \_\_\_\_\_ ,  
Last Name                      First Name                      Middle Name                      Chinese Name

3. Address of physician: \_\_\_\_\_  
\_\_\_\_\_

Phone #: \_\_\_\_\_ E-mail address: \_\_\_\_\_

4. Does the applicant have or have had any of the following?

	Yes	No		Yes	No
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			

5. Has he/she ever changed or advised to change his/her residence or occupation because of health reason?       Yes                       No

6. Has he/she ever received treatment or has treatment been recommended by a physician for physical or emotional condition?                       Yes                       No

7. Any continuing health problem?                       Yes                       No

If yes, what is it? \_\_\_\_\_

9. Does the applicant have any other disability which affects class attendance (such as vision, hearing, or walking disability)?

\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_