



International Student Medical Evaluation

Name _____ Student ID: 9 _____

Date of Birth: ____/____/____ Enrolling: ____ Year Fall Jan Term Spring Summer

Gender: _____ Email address: _____

Authorization and Consent

By signature, I verify that the information provided on this form is true. I hereby agree that University Health Services may evaluate and treat all injuries or illnesses for which help is sought as deemed necessary by duly licensed personnel, including immunizations and therapeutic procedures. In the case of a minor student (under the age of 19), this treatment may proceed without prior notification of the undersigned parent or guardian.

Student Signature _____ Date _____
 Signature of minor's parent/guardian _____

MEDICAL / SURGICAL HISTORY

Please indicate patient's medical history by circling the appropriate entries below:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abnormal Weight Loss | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Arthritis or joint pain | <input type="checkbox"/> Abnormal Pap smear |
| <input type="checkbox"/> Abnormal Weight Gain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Gout | <input type="checkbox"/> Breast Lump |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rashes | _____ # Live Births |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hives | _____ # Miscarriages |
| <input type="checkbox"/> Cancer or Tumor | <input type="checkbox"/> | <input type="checkbox"/> Moles | _____ # Abortions |
| <input type="checkbox"/> Glasses/ Contacts | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Seizure | Exposure to or close |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Frequent Bronchitis | <input type="checkbox"/> TIA | family member with |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke | HIV/AIDS |
| <input type="checkbox"/> Other problems with vision | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Numbness | Hepatitis |
| <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weakness | Tuberculosis |
| <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Memory Loss | |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Frequent Sinus Infections | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Anxiety/Panic Attacks | |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Considered/Attempted Suicide | |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Diarrhea, Constipation, or
other changes in bowel habits | <input type="checkbox"/> Eating Disorder | |
| <input type="checkbox"/> Recurrent Sores in Mouth | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Cutting | |
| <input type="checkbox"/> Frequent Chest Pain | <input type="checkbox"/> Colitis | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Head injury or concussion | |
| | <input type="checkbox"/> Kidney Problems | | |
| | <input type="checkbox"/> Sexually Transmitted Diseases | | |

Other medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____

List all surgeries and hospitalizations:

1. _____
2. _____
3. _____
4. _____
5. _____



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Surname Given Name

FAMILY HISTORY

Please indicate if there is a family history of any of the following:

- Heart Disease Diabetes Cancer High cholesterol Sudden unexpected death before age 50
- Allergies/Asthma Thyroid Disease Blood disorders Liver or Kidney problems

PHYSICAL EXAMINATION *(must be within the past 6 months)*

Age	Wt.	Ht.	BMI	B/P	Pulse	Labs
Contact Lenses		<input type="checkbox"/> yes	<input type="checkbox"/> no	Visual Acuity: OD 20/_____		<input type="checkbox"/> Corrected
Glasses		<input type="checkbox"/> yes	<input type="checkbox"/> no	OS 20/_____		<input type="checkbox"/> Uncorrected

	Normal	Abnormal	Remarks
General appearance			
Eyes/Ears/Nose/Throat			
Lymph nodes			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurological			
Skin			
Psychiatric			

The patient is currently under treatment for the following medical or emotional condition(s): _____

MEDICATIONS

ALLERGIES

RECOMMENDATIONS

 Signature of Physician/Physician Assistant/Nurse Practitioner

 Date of Examination

 Print Name of Physician/Physician Assistant/Nurse Practitioner

() _____
 Phone

 Address

Mail to: University Health Services
 Samford University
 800 Lakeshore Drive
 Birmingham, AL 35229-2452

Fax to: 205-726-4042

E-mail: SUHealth@samford.edu
 (.pdf attachments only)