



# 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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## Doctor of Ministry 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 \_\_\_\_\_  
\_\_\_\_\_

Family History: List major illnesses and/or causes of death of . . .

Parents: \_\_\_\_\_

Brothers or Sisters: \_\_\_\_\_

Wife or children \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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#### PORTION TO BE COMPLETED BY APPLICANT'S DOCTOR:

1. Does he/she have any physical deformities or limitations? (If so, please specify)

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

2. 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

3. List any major illnesses he/she has had (e.g., surgery, diabetes, heart trouble, seizures, venereal disease, tuberculosis)

4. Is he/she allergic to any drugs? \_\_\_\_ If so, which? \_\_\_\_\_

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

6. How long have you known or treated this person? \_\_\_\_\_

**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. running \_\_\_\_\_

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) \_\_\_\_\_

**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: \_\_\_\_\_