Report of Medical History

Study Abroad Program:		
Last Name:	First Name:	
Birth Date:	Day Phone:	
E-Mail:		
Name of Contact:		
Relation to the student:		
Address:		
City:	State:	Zip:
Country:		
Day Phone:	Evening Phone:	
Cell Phone:	E-Mail:	
Emergency Contact Information: (Secondary)		
Name of Contact:		
Address:		
City:	State:	Zip:
Country:		
Day Phone:	Evening Phone:	
Cell Phone:	E-Mail:	
Primary Physician Information		
Name of Physician:		
Address:		
City:	State:	Zip:
Country:		
Day Phone:	Fax:	

Please comment on any items checked **"YES"** and list all medications you are currently taking with their prescription and generic names below.

Additional Comments:

If you have any type of medical condition occur prior to departure (or after having submitted this form), please notify the Division of international Education. You must disclose any condition you have prior to departure. This includes any mental health condition for which you are being treated. In addition, we need to know in advance of any special treatment you may require while abroad. Your digital signature confirms that you understand and agree to the terms and conditions of this medical report and that you have disclosed all medical conditions to us. Failure to disclose all conditions to us could result in dismissal from the program.

The participant has indicated 'YES' to these terms and conditions.

Are you Allergic to:		Have you ever had:		Have you ever had:	
Penicillin	**YES / NO**	Eye Disease	**YES / NO**	Back Injury	**YES / NO**
Sulfa Drugs	**YES / NO**	Sinusitis	**YES / NO**	Disease or Injury of Joints or Bones	**YES / NO**
Other Drugs/ Medicine	**YES / NO**	Gum or Tooth Disease	**YES / NO**	Kidney Disease or Blood or Protein in Urine	**YES / NO**

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Food	YES / NO	Ear or Nose Disease	YES / NO	Head Injury with Unconsciousness	YES / NO
Anesthesia	YES / NO	Throat Disease	YES / NO	Diabetes	YES / NO
X-ray Dyes	YES / NO	Hay Fever-Asthma	YES / NO	Seizures-Epilepsy	YES / NO
Other/ Insects	YES / NO	Urticaria (Hives)	YES / NO	Depression or Emotional Problems	YES / NO
Have you ever had:		Chest Pain/ Pressure	YES / NO	Recurrent Headaches	YES / NO
Hepatitis	YES / NO	Positive HIV Test	YES / NO	Bleeding Disorder	YES / NO
Mumps	YES / NO	Heart Murmur	YES / NO	Bone or Joint Surgery	YES / NO
Red Measles (Rubella)	YES / NO	High Blood Pressure	YES / NO	Tumor, Cancer, Cyst	YES / NO
Chicken Pox	YES / NO	Chronic Cough	YES / NO	Meningococcal Vaccine	YES / NO
German Measles (Rubella)	YES / NO	Shortness of Breath	YES / NO	Date of last Tetanus: 11 / 2009	
Malaria	YES / NO	Rheumatic Fever	YES / NO	**Females Only:**	
Tuberculosis	YES / NO	Lung Disease	YES / NO	Irregular Periods	YES / NO
Infectious Mononucleosis	YES / NO	Palpitations (Heart)	YES / NO	Severe Cramps	YES / NO
Appendectomy	YES / NO	Peptic Ulcer Disease	YES / NO	Excessive Flow	YES / NO
Tonsillectomy	YES / NO	Gall Bladder Disease	YES / NO	Are you pregnant	YES / NO
Hernia Repair	YES / NO	Chronic Diarrhea or Colitis	YES / NO		

ADDITIONAL INFORMATION	
Are you presently taking any medicine on a regular basis? If YES, list in Comments.	YES / NO
Have you had any illness, injury or ever been hospitalized other than already noted? If YES, list in Comments.	YES / NO
Has your physical activity been restricted during the last five years? (Give Reason)	YES / NO
Have you been treated by clinics, physicians or other therapists in the last five years other than already noted?	YES / NO
Are you presently under a physician's care for a medical problem, including mental health?	YES / NO
Are you presently working with your home institution's disability office? If YES, list in Comments.	YES / NO
Do you smoke or use tobacco? If YES, specify and state amount in Comments. 62	YES / NO
Do you drink Alcohol? If YES, state amount in Comments.	YES / NO
Have you ever or are you currently receiving treatment for substance abuse?	YES / NO