Kyung Hee University Exchange Program

**Medical Assessment**

Please provide accurate information for the following questions.

|  |  |  |
| --- | --- | --- |
| **NAME OF THE STUDENT:** | | **SEX:** (M/F) |
| **DATE OF BIRTH:** (YYYY/MM/DD) | **NATIONALITY:** | |

|  |  |  |  |
| --- | --- | --- | --- |
| **QUESTION** | **YES** | **NO** | **EXPLAIN** |
| ① When and for what reason did he/she last consult a physician? (Please explain) |  | | |
| ② Have he/she had any serious ailment, injuries or diseases in the last five years? (If yes, please explain) |  |  |  |
| ③ Have he/she been hospitalized in the last two years?  (If yes, please explain) |  |  |
| ④ Have he/she ever been treated by a doctor for any mental, emotional, or anxiety disorder? (If yes, please explain and attach medical evaluation report.) |  |  |
| ⑤ Have he/she ever been addicted to any substance?  (If yes, please explain) |  |  |
| ⑥ Does he/she have any allergies? (If yes, please list them) |  |  |
| ⑦ Is he/she taking any prescribed medication?  (If yes, please explain) |  |  |
| ⑧ Is he/she on a special diet? (If yes, please explain in detail) |  |  |
| ⑨ Have he/she ever suffered from depression?  (If yes, please explain) |  |  |

※ THE ANSWERS MUST BE COMPLETED BY DOCTOR.

※ PLEASE ATTACH THE CERTIFICATE OF MEDICAL CHECKUP AS PROOF.

※ THE CERTIFICATE OF MEDICAL CHECKUP IS MANDATORY TO SUBMIT FOR **TUBERCULOSIS, HEPATITIS, AND HIV/AIDS**.

**Date(YYYY/MM/DD) Signature and name of the physician/doctor**