SAMFORD UNIVERSITY

International Student Medical Evaluation

Name_____ Student ID: 9 _ _ _ _ _ _ _ _ _
Surname *Given Name*

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:

◻Abnormal Weight Loss
◻Abnormal Weight Gain
◻Excessive Fatigue
◻Insomnia
◻Anemia
◻Cancer or Tumor

◻Glasses/ Contacts
◻Glaucoma
◻Cataracts
◻Other problems with vision

◻Hearing Loss
◻Ear Problems
◻Ringing in Ears

◻Allergies
◻Frequent Sinus Infections

◻Dentures
◻Dental Problems
◻Recurrent Sores in Mouth

◻Angina
◻Frequent Chest Pain
◻Irregular Heartbeat
◻Heart Murmur

◻ Rheumatic Fever
◻ High Cholesterol
◻ Heart Failure
◻ Heart Attack
◻ High Blood Pressure
◻
◻ Breathing Problems
◻ Frequent Bronchitis
◻ Emphysema
◻ Pneumonia
◻ Asthma
◻
◻ Heartburn
◻ Ulcer Disease
◻ Gallbladder Disease
◻ Blood in Stool
◻ Hepatitis
◻ Diarrhea, Constipation, or other changes in bowel habits
◻ Hemorrhoids
◻ Abdominal Pain
◻ Colitis

◻ Urinary Frequency
◻ Bladder Infections
◻ Kidney Problems
◻ Sexually Transmitted Diseases

◻ Arthritis or joint pain
◻ Gout
◻ Broken Bones

◻ Rashes
Hives
◻ Moles

◻ Seizure
◻ TIA
◻ Stroke
Numbness
◻ Weakness
◻ Memory Loss
◻ Headaches

◻ Depression
◻ Anxiety/Panic Attacks
◻ Considered/Attempted Suicide
◻ Eating Disorder
◻ Mental Illness
◻ Cutting

◻ Diabetes
◻ Thyroid Disease
◻ Head injury or concussion

◻ Abnormal Pap smear
◻ Breast Lump
◻ Pregnancy
_____ # Live Births
_____ # Miscarriages
_____ # Abortions

Exposure to or close family member with
HIV/AIDS
Hepatitis
Tuberculosis

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 [ ] yes [ ] no
Glasses [ ] yes [ ] no

Visual Acuity: OD 20/_____ [ ] Corrected
OS 20/_____ [ ] 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

_____
Print Name of Physician/Physician Assistant/Nurse Practitioner

_____
Address

_____
Date of Examination

( )_____
Phone

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)