

CERTIFICATE OF HEALTH

(Family name) (First name)

Name in full: _____ Sex: _____

Birth date: _____ Age: _____

Present Address: _____

1. History (Injury, illness or operation during the past five years)

Injury or illness: _____

Operation: _____

2. Examination

Height: _____ cm Weight: _____ kg

Blood Pressure Sys. _____ Dia. _____

Reflexes: Normal / Abnormal

Hearing: Left Normal / Abnormal Right Normal / Abnormal

Visual(correct): Left _____ () Right _____ ()

3. Anamnesis: Please indicate with + or -

Tuberculosis ☐ Cardiac Diseases ☐ Lung Disease ☐ Digestive Disease ☐

Kidney Disease ☐ Liver Disease ☐ Diabetes ☐ Epilepsy ☐ Allergy ☐

Hepatitis ☐ Other Communicable Disease ☐

4. Present Status: Please indicate with +, if you find any disease or abnormality, or with -, if not.

Tonsils, Nose or Throat ☐ Heart or Blood Vessels ☐ Lungs or Respiratory System ☐

Stomach or Digestive Status ☐ Genito-Urinary System ☐ Other Abdominal organs ☐

Brain or Nervous System ☐ Blood or Endocrine System ☐

Bones, Joints or Locomotor System ☐ Skin ☐ Eyes ☐ Venereal disease ☐

5. If you marked + to any of the above 3 and 4, please describe in detail each disease, and if the applicant is physically handicapped, the abnormality or impairment.

6. Describe in full on conditions of applicant's lungs (Including the result of chest X-ray examination and ECG, their dates)

7. Has the applicant ever suffered from any nervous or mental disorder?

8. Has the applicant ever suffered from any serious diseases?

9. In my opinion, the applicant's health and physical conditions are : (Please check)

Excellent _____ Good _____ Fair _____ Poor _____

10. In my opinion, the applicant is physically able to go abroad for study: (Please check)

Yes _____ No _____

Name & Title of Physician

Address

Signature

Date: _____ (DD/MM/YY)