McGilvary College of Divinity
Payap University
Chiang Mai 50000, Thailand

MEDICAL FORM

GENERAL INFORMATION

1. First Name _____ Last Name _____
2. Gender: ☐ Male ☐ Female
3. Date of Birth (Day/Month/Year _____
4. Emergency Contact (Full Name) _____

   Relationship to Applicant _____

   Address (Number and Street) _____

   Town/City _____ State/Province _____

   Postal (Zip) Code _____ Country _____

   Telephone _____ E-mail _____

FAMILY MEDICAL HISTORY (Indicate relationship to you)

___ Breast Cancer	___ Heart Attack	___ Overweight
___ Colon Cancer	___ Hypertension	___ Sickle Anemia
___ Diabetes	___ Liver Cirrhosis	___ Stroke
___ Elevated Cholesterol	___ Mental Illness	___ Tuberculosis

PERSONAL MEDICAL HISTORY Have you ever had any of the following? Please check, if "yes."

___AIDS	___Hypertension	___Back ache
___Allergies	___Malaria	___Breathlessness
___Colitis	___Mononucleosis	___Dizzy Spells
___Diabetes	___Pleurisy	___Frequent Colds
___Elevated Cholesterol	___Pneumonia	___Mental Illness
___Epilepsy	___Recurring gastrointestinal	___Migraine
___Fainting Spells	___Rheumatic Fever	___Palpitations
___Heart Disease	___Sinus Infection	___Skin Rash
___Hepatitis	___Tuberculosis	___Hearing Loss
___Hernia	___Typhoid Fever	___Visual Loss

*In a separate sheet of paper, please provide details for the disease you have checked, including the nature and date of the problem, medical diagnosis and the current status. If you are under treatment for any condition, your physician must describe the treatment plan.