**OSAKA UNIVERSITY STUDENT HEALTH DATA FORM**

**Student Information**

|  |  |  |
| --- | --- | --- |
| Student ID: | Department | |
| Name: | | |
| Date of Birth (dd/mm/yyyy): | Nationality: | Gender (Male/Female/Other): |

**Health History** (Describe if any)

|  |
| --- |
| Are you currently seeing a doctor?  □Yes　→　***Please bring us a letter of referral from your doctor.***  □No　→　If you have any medical/psychological conditions that concerns you, please describe. |
| Are you currently on any medications?  □Yes　→　Please describe the name of medicines you are taking.  ***If they are prescribed medicines, please bring us a letter of referral from your doctor.***  □No |
| Do you have any allergies (drug, food, insect, latex, etc.)?  □Yes　→　Please describe which substances you are allergic to.  □No |
| Special Needs:  If you have a disability (this includes a specific learning difficulty or medical condition) that may affect your studies at the university or which might require special arrangements or facilities, please describe it. |

**Past History** (Check the appropriate box)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Specific Infectious Diseases | | | | |
|  | | | Yes | No |
| * Tuberclosis | | |  |  |
|  | Yes | Vaccinated | Antibody exists | Unknown |
| * Measles (Rubeola) |  |  |  |  |
| * German measles (Rubella) |  |  |  |  |
| * Chicken pox (Varicella) |  |  |  |  |
| * Mumps |  |  |  |  |
| * Meningococcus |  |  |  |  |
| Mental Diseases | | | Yes | No |
| * Mood disorders (Depression, Bipolar disorders, etc.) | | |  |  |
| * Anxiety disorders (Social anxiety disorders, Panic disorders, Obsessive-compulsive disorders, etc.) | | |  |  |
| * Eating disorders (Anorexia nervosa, Bulimia nervosa, etc.) | | |  |  |
| * Schizophrenia spectrum disorders (Schizophrenia, psychotic disorders, etc.) | | |  |  |
| * Developmental disorders (Autism spectrum disorders, ADHD, Specific learning disorders, etc.) | | |  |  |
| * Other mental diseases (If “Yes,” specify:) | | |  |  |
| Medical Conditions | | | Yes | No |
| * Allergies | | |  |  |
| * Anemia | | |  |  |
| * Asthma | | |  |  |
| * Bleeding/clotting disorder | | |  |  |
| * Inflammatory Bowel Disease | | |  |  |
| * Heart disease | | |  |  |
| * Neurological disease | | |  |  |
| * Kidney disease | | |  |  |
| * Hepatitis | | |  |  |
| * Diabetes | | |  |  |
| * Pneumonia | | |  |  |
| * Other medical diseases (If “Yes,” specify:) | | |  |  |

**Comment by physician/healthcare provider** (Please comment on any positive responses to the health history above.)

**Signature of physician/healthcare provider and date:**