**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:**