SOOKMYUNG WOMEN'S UNIVERSITY

PERSONAL MEDICAL ASSESSMENT

Name				**Home Univ**		
Gender:		**HEIGHT**	cm	**WEIGHT**		kg
① When and for what reason did you last consult a physician? (Please explain in the adjacent space.)						
QUESTION				YES	NO	IF ***YES***, PLEASE EXPLAIN
② Have you ever had an infectious disease that posed a risk to public health (**such as, but not limited to, tuberculosis**						
③ 1. allergies?						
2. high blood pressure?						
3. diabetes?						
4. any type **of Hepatitis**?						
④ Have you ever suffered from or been treated for depression, anxiety, or any other mental or mood disorder? (If you have received treatment, please explain and attach an official medical report.)						
⑤ Have you ever been addicted to alcohol?						
⑥ Have you ever abused any narcotic, stimulant, hallucinogen or other substance (whether legal or prohibited)?						
⑦ Have you been hospitalized in the last two (2) years?						
⑧ Have you had any serious injury, ailment or sickness in the last five (5) years?						
⑨ Do you have any visual or hearing impairments?						
⑩ Do you have any physical disabilities?						
⑪ Do you have any cognitive/mental disabilities?						
⑫ Are you taking any prescribed medication?						
⑬ Are you on a special diet?						
QUESTION				YES	NO	IF ***NO***, PLEASE EXPLAIN
⑭ If necessary, are you prepared to undergo physical tests to verify the answers given in response to questions above?						

The answers I have given above are true and correct to the best of my knowledge. If my answers contain any kind of falsehood, I will take any legal responsibility.

Date(YYYY. MM. DD) . . .

NAME OF THE APPLICANT SIGNATURE OF THE APPLICANT

SOOKMYUNG WOMEN'S UNIVERSITY

OFFICIAL MEDIACL EXAMINATION

1. Personal Information

Full Name	
Gender	
Date of Birth (YYYY.MM.DD)	
Nationality	
Home University	

2. [Mandatory] Chest X-ray examination

Date taken (YYYY.MM.DD)	
Findings	
Tuberculosis	☐ NO ☐ YES

* For student who wants to stay at on-campus housing, the x-ray should be taken within 3 months before check-in dates. You can submitted this result later than the application period.

3. [Recommended] Immunization examination

Type	Vaccination	Vaccination Date 1ST (YYYY.MM.DD)	Vaccination Date 2nd (YYYY.MM.DD)	Vaccination Date 3rd (YYYY.MM.DD)
Hepatitis A	□ YES □ NO			
Hepatitis B	□ YES □ NO			
MMR	□ YES □ NO			

This is to certify that the above named applicant has gone through a general medical examination and the findings indicated here are true to the best of my knowledge.

Date YYYY.MM.DD	
M.D	
Signature	

Hospital and Contact Information