



UNIVERSITY OF THE NATIONS PHNOM PENH



STUDENT HEALTH FORM

Identity:

Last name: _____ First name: _____ Middle: _____

Home phone: _____ Email: _____

Medical information:

We require students from the west; America, Europe and Korea to have health insurance which covers medical evacuation to Bangkok or home country.

Name of insurance carrier: _____ Contact phone: _____

Policy type: _____ Policy number: _____

Expiration date: D _____ M _____ Y _____

Brief description of coverage: _____

In case of emergency contact: _____ Relationship: _____

Street/Box: _____

City/Town: _____ State: _____ Zip: _____

Country: _____ Phone: _____

Health history: (Answer all questions. Explain positive answers below or on a separate piece of paper.)

Do you now have, or have you ever had, any of the following?

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1-Skin condition | <input type="checkbox"/> | <input type="checkbox"/> | 15-Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | 25-Jaundice |
| <input type="checkbox"/> | <input type="checkbox"/> | 2-Eye trouble | <input type="checkbox"/> | <input type="checkbox"/> | 16-High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 26-Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | 3-Ear trouble | <input type="checkbox"/> | <input type="checkbox"/> | 17-Low blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 27-Intestinal troubles |
| <input type="checkbox"/> | <input type="checkbox"/> | 4-Head injury | <input type="checkbox"/> | <input type="checkbox"/> | 18-Rheumatism/Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | 28-Recurrent diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | 5-Recurrent headache | <input type="checkbox"/> | <input type="checkbox"/> | 19-Back problems | <input type="checkbox"/> | <input type="checkbox"/> | 29-Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | 6-Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | 20-Dislocation of joints | <input type="checkbox"/> | <input type="checkbox"/> | 30-Kidney disease |
| <input type="checkbox"/> | <input type="checkbox"/> | 7-Fainting spells | <input type="checkbox"/> | <input type="checkbox"/> | 21-Broken bones | <input type="checkbox"/> | <input type="checkbox"/> | 31-Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | 8-Mental/Nervous disorder | <input type="checkbox"/> | <input type="checkbox"/> | 22-Stomach/Duodenal ulcer | <input type="checkbox"/> | <input type="checkbox"/> | 32-Gall bladder problem |
| <input type="checkbox"/> | <input type="checkbox"/> | 9-Depression | <input type="checkbox"/> | <input type="checkbox"/> | 23-Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | 33-Cancer/Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | 10-Paralysis | <input type="checkbox"/> | <input type="checkbox"/> | 24-Surgery | <input type="checkbox"/> | <input type="checkbox"/> | 34-Female conditions |
| <input type="checkbox"/> | <input type="checkbox"/> | 11-Insomnia | <input type="checkbox"/> | <input type="checkbox"/> | Appendectomy | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | 12-Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy | <input type="checkbox"/> | <input type="checkbox"/> | Severe cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | 13-Hay fever/Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Hernia repair | <input type="checkbox"/> | <input type="checkbox"/> | Excessive flow |
| <input type="checkbox"/> | <input type="checkbox"/> | 14-Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> | Now pregnant |

Specify:_____ Specify:_____ Other:_____

Other illnesses or conditions:_____

Explanations for above:_____

Are you presently under a doctor's care? []Yes []No

Specify:_____

Are you presently taking any medication? []Yes []No

Specify:_____

Are you allergic to any drugs/medications? []Yes []No

Specify:_____

Are you now receiving or did you ever receive compensation for disability from any source? []Yes []No

Specify:_____

Do you have any physical impairments, handicaps or health conditions which require special attention?

[]Yes []No Specify:_____

How would you rate your overall health condition? []Excellent []Good []Fair []Poor

Disease history:

Have you ever had any of the following COMMUNICABLE DISEASES?

- | | | | | | |
|-----|-----|---------------------|-----|-----|-----------------|
| Yes | No | | Yes | No | |
| [] | [] | 1-Chickenpox | [] | [] | 5-Pertussis |
| [] | [] | 2-Measles (rubella) | [] | [] | 6-Scarlet fever |
| [] | [] | 3-Measles (rubeola) | [] | [] | 7-Tuberculosis |
| [] | [] | 4-Mumps | [] | [] | 8-Other |

Family history:

Have any of your immediate family members ever had any of the following?

- | | | | | | |
|-----|-----|------------------|-----|-----|------------------------|
| Yes | No | | Yes | No | |
| [] | [] | 1-Tuberculosis | [] | [] | 6-Arthritis |
| [] | [] | 2-Diabetes | [] | [] | 7-Stomach disease |
| [] | [] | 3-Kidney disease | [] | [] | 8-Asthma/Hay fever |
| [] | [] | 4-Heart disease | [] | [] | 9-Epilepsy/Convulsions |
| [] | [] | 5-Hypertension | [] | [] | 10-Cancer |

Immunizations:

DISEASE	BASIC (year)			BOOSTER (year)		
	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose
Diphtheria:	_____	_____	_____	_____	_____	_____
Tetanus:	_____	_____	_____	_____	_____	_____
Pertussis:	_____	_____	_____	_____	_____	_____
Polio:	_____	_____	_____	_____	_____	_____
Rubella:	_____	_____	_____	_____	_____	_____
Mumps:	_____	_____	_____	_____	_____	_____
Hepatitis A:	_____	_____	_____	_____	_____	_____
Hepatitis B:	_____	_____	_____	_____	_____	_____

Please mail all forms to:

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U of N Cambodia
PO. Box 1415
Phnom Penh
Cambodia

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Email: dts@uofncambodia.org
Website: www.uofncambodia.org