MEDICAL RECORD

- **FULL-TIME STUDENTS MUST HAVE BOTH SIDES OF THIS FORM COMPLETED.**
- **PART-TIME STUDENTS NEED ONLY COMPLETE THIS SIDE.**

ADMISSIONS OFFICE:

Massillon Baptist College
1219 Overlook Ave., S.W.
Massillon, OH 44647-7723
Phone: (330) 830-5902
Fax: (330) 830-5980

Name: _____

Age _____ Gender: _____

Marital Status: _____
(single, married, widowed, divorced)

Occupation: _____

Student to Complete
HISTORY

Check those which apply to you personally [X]:

[ ]	Diabetes	[ ]	High Blood Pressure
[ ]	Epilepsy	[ ]	Low Blood Pressure
[ ]	Rheumatic Fever	[ ]	Tuberculosis
[ ]	Arthritis	[ ]	Thyroid Disease
[ ]	Scarlet Fever	[ ]	Anemia
[ ]	Frequent Head Colds	[ ]	Mumps
[ ]	Frequent Tonsillitis	[ ]	Sinus Disease
[ ]	Frequent Chest Colds	[ ]	Measles
[ ]	Frequent Headaches	[ ]	Chicken Pox
[ ]	Fainting Episodes	[ ]	Whooping Cough
[ ]	Pleurisy	[ ]	Venereal Disease
[ ]	Allergies (List)	[ ]	Kidney or Bladder Disease
[ ]	Pneumonia	[ ]	Jaundice
[ ]	Eye Problems	[ ]	Heart Disease
[ ]	Malaria	[ ]	Liver Disease
[ ]	Diphtheria	[ ]	Service with U.S.A. Overseas
[ ]	Typhoid Fever	[ ]	Weight Loss of Over 10 Pounds During Last Year

History of Injuries: If any, give short account. If none, indicate "none."

History of Operations: If any, When? What? If none, indicate "none."

Have you ever sought psychiatric counsel? { } Yes { } No

If yes, please explain

Family History (parents, grandparents, brothers, sisters):

[ ]	**Cancer**	**[ ]**	**Tuberculosis**	**[ ]**	**Heart Disease**
[ ]	**Leukemia**	**[ ]**	**Kidney Disease**	**[ ]**	**Diabetes**
[ ]	**Allergy**	**[ ]**	**Venereal Disease**	**[ ]**	**Mental Disease**
[ ]	**Brain Tumor**	**[ ]**	**Arthritis**	**[ ]**	**Epilepsy**

THIS SIDE TO BE COMPLETED BY EXAMINING PHYSICIAN

(Dormitory Students Only)

Name _____ Date _____

Age _____ Gender _____

Height _____ Weight _____ Blood Pressure _____ Pulse

Does this individual need to wear glasses or contacts? ____ Yes ____ No

E.E.N.T.

Heart

Lungs

Abdomen

Extremities

Date of last tetanus shot: _____

Does this person appear to be physically capable of being enrolled in school?

Is this person taking any prescribed medication?

If yes, please explain: _____

Please include an immunization record with this form.

Please list any limitations:

Physician _____Address _____

_____

_____