OFFICE USE ONLY

Date received _____

By _____

HEALTH HISTORY

ASSEMBLIES OF GOD GRADUATE SCHOOL OF THEOLOGY (AGGST)

To Applicant: Please fill out this form; if necessary, write explanations on a separate sheet of paper. A qualified medical authority must complete the medical report. Mail the completed forms to AGGST, B.P. 2313, Lomé, Togo, or scan and send them to registrar@waast.org.

Surname _____

First Name(s) _____

Permanent Address _____

City _____ State _____ Country_____

1. Is there any history of cancer, tuberculosis, AIDS, or insanity in your family? _____
   If yes, explain: _____
   _____

2. Have you ever lived with anyone who had tuberculosis or AIDS? ____ If so, describe the contact:_____
   Do you have a chronic cough? _____ Have you ever had a chest X-ray? _____
   When? _____

3. Where applicable, give the approximate age at which the following diseases occurred:

Asthma _____	Mumps _____	Scarlet Fever _____
Diabetes _____	Malaria _____	Smallpox _____
Filaria _____	Polio _____	Diphtheria _____
Typhoid _____	Epilepsy _____	Leprosy _____
Hepatitis _____	Internal	Thyroid
AIDS _____	Parasites _____	(Goiter) _____
Whooping	Venereal	
Cough _____	Disease _____	

4. List any operations you have had and the approximate dates _____

5. Do you have a crippling deformity? _____ If so, explain _____

6. Have you ever been subject to fainting spells? _____ Seizures? _____ Epilepsy? _____ If so, explain _____

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MEDICAL REPORT *for* _____

To the medical officer or doctor making this report:

The bearer has applied for admission to the Assemblies of God Graduate School of Theology, Lomé, Togo. All students are required to have medical clearance before being admitted. Please make a complete examination and answer the following questions concerning the applicant. Thank you for your assistance. If you have any further remarks, please write them on an additional sheet of paper.

Does the bearer have any evidence of the following?

Yes	No		Yes	No	
( )	( )	Tuberculosis	( )	( )	Heart trouble
( )	( )	Leprosy	( )	( )	Allergies _____ _____
( )	( )	Venereal disease	( )	( )	Stomach or intestinal disorders
( )	( )	Hepatitis	( )	( )	Normal vision without glasses R _____ L _____
( )	( )	Internal parasites	( )	( )	Tooth decay
( )	( )	Any other infectious or or contagious diseases	( )	( )	Hernia ( ) R ( ) L

Blood pressure: Sist. _____ Dist. _____ Urine: Albumin _____ Sugar _____

Remarks on above _____

_____

_____

Title and name of official filling out this report _____

Signature _____ Date _____

Address _____

City _____ State _____ Country _____

Revised July 2011