

CONFIDENTIAL HEALTH FORM

Form M.T.I. 3

TO THE STUDENT: This information is treated confidentially and separate from your academic records. Answer all questions in ink or by typing in English.

Date of expected enrollment _____

Name: _____
Last or Family Name First Name Middle Name

Permanent Address: _____

Local Address: _____

Social Insurance # _____ Medical Insurance # _____

Citizen of: _____

Name, Relationship and Address of Next of Kin: _____

_____ Phone# _____

A. PERSONAL HISTORY: Please answer all questions. Comment on all positive answers in the space below or on a separate sheet. Have you ever had, or do you have any of the following?

	Yes	No		Yes	No
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Eye Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Ear Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism/Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Headache	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation of Joints	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Mental or Nervouse Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Other-Specify	<input type="checkbox"/>	<input type="checkbox"/>
Allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Duodenal Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sulfonamides	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Serum	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Foods (specify)	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Troubles	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever, Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Anaemia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>

Are you presently under a doctor's care for any condition? NO YES (Specify) _____

Are you taking any medication at this time? NO YES (Specify) _____

Do you now or have you ever received any compensation for disability from any source.

NO YES (Specify) _____

Height _____ Weight _____ (lbs.) Overweight Underweight

Have you ever had any of the following communicable diseases?

	YES	NO		YES	NO
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>	Pertussis	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubella)	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Measles (Rubeola)	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY

Have any of your relatives ever had any of the following? Relationship

<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Arthritis	
<input type="checkbox"/> Stomach Disease	
<input type="checkbox"/> Asthma Hay fever	
<input type="checkbox"/> Epilepsy, convulsions	

Physician's Name (PLEASE PRINT): _____

ADDRESS: _____

Please direct all forms to:



Dean of Students
Ministry Training Institute
905 Badke Rd.
Kelowna, B.C V1X 5Z5