INTERNATIONAL BUDDHIST COLLEGE (THAILAND)
国 际 佛 教 大 学（泰 国）
Tel/Fax : (+66) 044 452 521 : Web site : www.ibc.ac.th

MEDICAL EXAMINATION身体检查

(Please fill in this form completely using capital letters 请用大写字母填写)

1. To be completed by applicant由申请者填写

PERSONAL PARTICULARS 个人资料			
Name *(As in Passport for International Student) (As in ID for Thai Student)* *姓名（泰国籍学生填写身份证姓名；其他国籍学生填写护照姓名）*			
ID No. or Passport No. 身份证号码 或 护照号码			
Date of Birth 出生日期 / / *Day日 Month月 Year年*		Age年龄	
Gender性别: ☐ Male男 ☐ Female 女		Marital Status婚姻状况: ☐ Married已婚	☐ Single未婚
Place / Country of Birth 出生地区 / 国家		Nationality国籍	

MEDICAL HISTORY 健康史
Recently have you ever had or been told that you had any illness? *(If yes, please give detail)* 近期，您是否患有任何疾病？*(如是，敬请阐述)*
Have you under go any surgical operation? *(If yes, please give detail)* 您是否接受过手术 ？*(如是，敬请阐述)*
Have you ever had or been told that any serious illness or disorders in your family? *(If yes, please give detail)* 您的家族是否曾染上任何遗传性的严重疾病或精神问题？*(如是，敬请阐述)*
Have you ever had any allergies? *(If yes, please give detail)* 您是否患有任何过敏症？*(如是，敬请阐述)*
Have you ever had any disturbing social habits? 您是否有染上任何不良的生活习惯？ Tobacco 烟草: ☐ Yes ☐ No　　Drugs 毒品: ☐ Yes ☐ No Alcohol 酒精: ☐ Yes ☐ No　　Others 其他: ☐ Yes ☐ No
Immunisations : 免疫法：
If you currently take any medication/drugs, please give details 如您有服食任何药物/毒品，敬请阐述

DECLARATION 声明
I, _____*(name)* hereby declare that all information in this form is complete and correct. 本人，_____*（姓名）*谨此声明：我所提供的一切资料均完整属实。 Applicant's Signature申请人签名: _____ Date日期: _____

2. To be completed by Doctor由医生填写

MEDICAL EXAMINER'S REPORT 身体检查报告

Chest x-ray (CXR) 胸部X光

Urinalysis 尿液检查

Glucose 糖份	Albumin 白蛋白	Specific gravity比重

Blood Test血液检查

Blood Group/血型	Rh factor/Rh 因子
HIV/HIV血清	☐ Positive阳性 ☐ Negative阴性
Hepatitis B/B型肝炎	☐ Positive 阳性 ☐ Negative阴性

Others *(indicated)* 其它 *(请列明)*

CERTIFIED MEDICAL REPORT 医生检查报告

Height高度 _____cm公分

Weight 体重 _____ kg 公斤

Blood Pressure血压 _____/_____mmHg

Pulse脉搏 _____rate per minute 每分钟次数

Heart心脏

Lung肺部

Physical Examination全身检查

General medical report of the applicant 医药报告

DOCTOR 'S PARTICULARS 医生资料

Name姓名 _____

Official Stamp印章

_____

Signature 签名

Telephone No. 联络电话号码 : _____ Date日期: _____