



Pan- Africa Theological Seminary Health History Form

OFFICE USE ONLY

Date received: _____

By: _____

INSTRUCTIONS:

1. To the applicant: Please fill out this form as accurately as possible. If necessary, write explanations on a separate sheet of paper. A qualified medical authority must complete and sign the attached medical report. Complete the section labeled "Applicant's Information" then give to your physician.

Promptly mail both forms to:

Admissions Office
Pan-Africa Theological Seminary
PO Box 6200
Springfield, MO 65801, USA.

Courier address:
580 W. Central Street
Springfield, MO 65802, USA
Phone: (417) 862-7725. Fax: (417) 862-1867
Email: info@pathseminary.org

Applicant's Information:

1. Name: _____

First
Middle
Last
2. Mailing address: _____

PO Box or Street Address
City
Country
Code
3. Applicant's Signature: _____ Date: _____
4. Is there any history of cancer, tuberculosis, AIDS, depression, or insanity in your family? Yes No
 If yes, explain: _____
5. Have you ever lived with anyone who had tuberculosis or AIDS? Yes No
 If so, describe the contact: _____
6. Do you have a chronic cough? Yes No
7. Have you ever had a chest X-ray? Yes No If so, when? _____

8. Where applicable, give the approximate year at which the following diseases occurred:

Disease	Year	Disease	Year	Disease	Year
AIDS/HIV		Hernia		Polio	
Asthma		Hepatitis		Scarlet Fever	
Depression		Hypertension		Smallpox	
Diabetes		Internal Parasites		Thyroid (Goiter)	
Diphtheria		Leprosy		Typhoid	
Epilepsy		Malaria		Venereal Disease	
Filaria		Mumps		Whooping Cough	

Applicant Information continued:

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

10. Do you have a crippling deformity? Yes No If so, explain: _____

11. Have you ever been subject to fainting spells, seizures, or epilepsy? Yes No
If so, explain: _____

Physicians Report

INSTRUCTIONS:

To the medical officer or doctor making this report:

The bearer has applied for admission to the Pan-Africa Theological Seminary, Lomé, Togo. All students are required to have medical clearance before being admitted. Please conduct a complete medical examination, then 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.

Medical Report for (Patient's Name): _____

1. Normal vision without glasses: R _____ L _____

2. Blood pressure: Systolic _____ Diastolic _____

3. Urine: Albumin _____ Sugar _____

4. Does the applicant have any evidence of the following:

Disease	Yes	No	Disease	Yes	No	Disease	Yes	No
AIDS			Internal parasites			Tooth decay		
Heart trouble			Leprosy			Tuberculosis		
Hepatitis			Stomach or intestinal disorders			Venereal disease		
Allergies (specify) _____			Hernia (if yes, specify) R__ L__					

5. Does the applicant have evidence of any other infectious or contagious diseases or do you have remarks on any of the above? _____

6. Is there anything that might prevent the applicant from carrying a full load of studies? Yes No
If yes, please explain: _____

7. Name of physician filling out this report: _____

Title: _____ Date: _____

Address: _____

City: _____ Country: _____

Signature: _____