

Medical

Mail to
Admissions Office

history

Golden State Baptist College, 3520 De La Cruz Blvd., Santa Clara, CA 95054

Please type or print in ink. Please fill out completely.

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Telephone Number: (____) _____

Birth Date: ____ / ____ / ____ Social Security Number: _____ - _____ - _____

Do you intend to enroll: Part-time? Full-time? Do you intend to live in the dormitories? Yes No

Do you have medical insurance? Yes No

Medical insurance company: _____ Policy #: _____

History of Injuries: Give a short account. If none, indicate "none." _____

History of Operations: If any, what? when? If none, indicate "none." _____

List any medications you take regularly: _____

Are you allergic to any medications? _____

Have you ever sought psychiatric counsel? Yes No If yes, please explain in a separate letter, including circumstances and medication which was given.

Student History

(Check those you have had with an X)

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Headaches (frequent) | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Service with U.S.A. overseas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Disease |
| <input type="checkbox"/> Chest Colds (frequent) | <input type="checkbox"/> Kidney or Bladder Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tonsillitis (frequent) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Trouble With Eyes |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Malaria | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Drug Flashbacks | <input type="checkbox"/> Measles | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Weight Loss (over 10 pounds in last year) |
| <input type="checkbox"/> Fainting Attacks | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Head Colds (frequent) | <input type="checkbox"/> Pneumonia | |

Family History

(Parents, grandparents, brothers and sisters)

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disease |
| <input type="checkbox"/> Brain Tumors | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Venereal Disease |