



District 4760

Applicant Name	Maria Souza Silva
----------------	-------------------

# Long-Term Exchange Program

## Medical History and Examination

**Physician:** This student is considering a year abroad as an exchange student. Insufficient, inadequate, or improper information about medications or psychiatric, psychological, or other medical problems could endanger the student's life while overseas. Allergy information is especially crucial to host family placement and student well-being. An immediate relative of the applicant may **not** complete the examination or fill out this form.

Please type or print clearly. Please submit four copies of the form, with original signatures in **blue ink** on each copy.

<b>Applicant's Full Legal Name</b>		<b>Gender</b>	<b>Date of Birth</b> (e.g., 01/Jan/1999)
Maria Souza Silva (nome do intercambista)		<input type="checkbox"/> Male <input type="checkbox"/> Female	01/Feb/1900
<b>Address — Street</b>			
Rua Qualquer, 400 – casa 2 – Bairro Regional (endereço)			
<b>City</b>	<b>State/Province</b>	<b>Postal Code</b>	<b>Country</b>
Belo Horizonte	Minas Gerais	30.999-111	Brazil
<b>Home Phone</b>	<b>Mobile Phone</b>	<b>E-mail</b>	
+55 31 9999 9999	-	maria9@hotmail.com	

### Medical History

<b>1. How long has the applicant been the patient of the physician?</b>		12 Years	
<b>2. Has the applicant ever been diagnosed with or received treatment, attention, or advice from a physician or other practitioner for:</b>			
	<b>Yes</b>	<b>No</b>	
a. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	n. Liver disease/hepatitis
b. Anorexia/bulimia/other eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	o. Menstrual disorders
c. Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	p. Mental disorders
d. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	q. Pneumonia
e. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	r. Rheumatic fever
f. Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	s. Serious headache/migraine
g. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	t. Stomach ulcer
h. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	u. Typhoid fever
i. Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	v. Urinary tract infection
j. Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	w. Vertigo/dizziness
k. Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	x. Visual problems
l. Hernia	<input type="checkbox"/>	<input type="checkbox"/>	y. Eyeglasses/contact lenses
m. Malaria	<input type="checkbox"/>	<input type="checkbox"/>	
<b>3. Has the applicant:</b>			
a. Had any surgical operation not revealed in question 2, or gone to a hospital, clinic, dispensary, or sanatorium for observation, examination, or treatment not revealed in question 2?	<b>Yes</b>	<b>No</b>	
b. Taken any prescribed medication in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Presented any history or current evidence of nervous, emotional, or mental abnormality, functional nervous breakdown, nervous fatigue, depression, suicide attempts, eating disorders, or antisocial behavior?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Ever used heroin, cocaine, marijuana or other hallucinogens, amphetamines, or other street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Ever received treatment for or advice about a problem with alcohol or drug use, either from a physician/other practitioner or an organization that assists those who have an alcohol or drug problem?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Had excessive weight gain or loss recently?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Suffered chest pain, wheezing, shortness of breath, or fainting episodes?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Suffered chronic diarrhea, vomiting, abdominal pain, or constipation?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Exhibited chronic skin conditions (e.g., severe acne, eczema, psoriasis)?	<input type="checkbox"/>	<input type="checkbox"/>	
j. Suffered weakness of neurological or muscular skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>	
k. Had any dietary restrictions? If yes, specify and note reason (medical, religious, personal choice):	<input type="checkbox"/>	<input type="checkbox"/>	
<b>If yes for any parts of questions 2 and 3, please explain:</b>			
<b>Question</b> (e.g., 2e)	<b>Nature and severity of disorder, diagnosis, frequency of attacks, and treatment</b>		<b>Dates and duration</b>
2a	MEDICATIONS CONTAINING SULPHUR (exemplo)		