AMBS

Anabaptist Mennonite
Biblical Seminary

ADMISSIONS
3003 Benham Avenue, Elkhart, IN 46517
ph: 800.964.2627 or 574.296.6266
fx: 574.295.0092
admissions@ambs.edu • www.ambs.edu

medical history

All international students need to fill out a Medical History and have a physical examination before admission. A copy of any complete physical examination within six months of the date of submission will satisfy this requirement. Medical history must be current, and it is **extremely important that ALL IMMUNIZATIONS are up to date**.

All information received by Admissions is kept in strict confidence in your personal file; hence, no pertinent information should be withheld. Medical information is confidential, and information can be released only upon your written consent.

Students also are required to purchase health insurance through AMBS before they are allowed to register for classes.

Please complete all questions on page 1, sign the form and send it with your applica-tion packet to AMBS. Have your physician complete the Physician's Physical Examination form and sign it. After completing the form, your doctor must mail it directly to AMBS, 3003 Benham Avenue, Elkhart, IN 46517, USA.

Complete and sign this form. Your application is acceptable only when this document is correctly and fully completed.

Name _____ Gender: ☐ male ☐ female
First Middle (Maiden) Surname

Address _____
Street, Box number or Rural Route City State Postal Code Country

Date of birth _____ Country of birth _____ Denomination _____
month day year

family health history

Check each item:	yes	no	relationship
Tuberculosis	☐	☐	
(If yes, give details below, year exposed and provide X-ray)			
Diabetes	☐	☐	
High blood pressure/stroke	☐	☐	
Heart trouble	☐	☐	

Check each item:	yes	no	relationship
Cancer	☐	☐	
Asthma, hay fever, hives	☐	☐	
Epilepsy or convulsions	☐	☐	
Nervous or mental disease	☐	☐	

Mother living? ☐ ☐ No. of brothers living _____ No. of sisters living _____
Father living? ☐ ☐ If dead, give relationship and cause of death: _____

personal health history

Have you ever had, or have you now, any of the following: (In lines of multiple statements, cross out the inapplicable words.) **Explain all positive answers below.**

Check each item:	yes	no
Heart trouble	☐	☐
High or low blood pressure	☐	☐
Rheumatic fever/Scarlet fever	☐	☐
Cold sores or Herpes	☐	☐
Diphtheria	☐	☐
Mumps	☐	☐
Whooping cough	☐	☐
Measles	☐	☐
Chickenpox	☐	☐
Mononucleosis	☐	☐
Smoke	☐	☐

Check each item:	yes	no
Wear glasses or contacts	☐	☐
Nose or throat trouble	☐	☐
Ear trouble	☐	☐
Sinusitis	☐	☐
Chronic or frequent colds	☐	☐
Hay fever, allergy	☐	☐
Asthma	☐	☐
Reaction to serum or drugs	☐	☐
Chronic cough	☐	☐
Shortness of breath	☐	☐
Take medication regularly	☐	☐

Check each item:	yes	no
Tuberculosis	☐	☐
Stomach/intestinal trouble	☐	☐
Jaundice or liver disease	☐	☐
Appendicitis	☐	☐
Rupture or hernia	☐	☐
Skin diseases, boils	☐	☐
Painful or trick shoulder	☐	☐
Trick or locked knee	☐	☐
Arthritis	☐	☐
Bone or joint problems	☐	☐
Any drug side effects	☐	☐

Check each item:	yes	no
Thyroid	☐	☐
Surgery	☐	☐
Malaria	☐	☐
Dizzy or fainting spells	☐	☐
Epilepsy or convulsions	☐	☐
Drink alcohol regularly	☐	☐
Emotional problems	☐	☐
Sugar or albumin in urine	☐	☐
Kidney or bladder trouble	☐	☐
Diabetes	☐	☐
See a doctor regularly	☐	☐

If yes, or any other disease, give details: _____

Has your health been: ☐ **good?** ☐ **fair?** ☐ **poor?** **If not good, please explain:** _____

statement of authorization

The information provided is true to the best of my knowledge. _____ _____
Signature of applicant Date

AMBS physician's physical examination

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To be completed and signed by the applicant.

I authorize the physician to complete this form and send it to AMBS (address at left):

_____ _____
Signature of applicant Date

To be completed and signed by the physician.

Patient name _____ Date _____
First Middle (Maiden) Surname

Sex_____ Age_____ Height _____ Weight _____ Blood pressure _____ Pulse _____

Build: ☐ slender ☐ medium ☐ heavy ☐ obese

Vision: Without glasses: Right 20/ _____ Left 20/ _____
With glasses: Right 20/ _____ Left 20/ _____

Hearing: Right _____ 15 Left 15

Color vision _____ Jaeger_____

If correction is needed, please refer immediately.

clinical evaluation

Check each item in proper column.
Enter "N." if not evaluated.

Note: Give details of each abnormality.
Enter corresponding item number before each comment.

		normal	abnormal
1.	Head, neck, face and scalp	☐	☐
2.	Nose and sinuses	☐	☐
3.	Mouth, teeth, gingiva and throat	☐	☐
4.	Ears—general (canals, drums, etc.)	☐	☐
5.	Eyes—general (lids, pupils, motions, etc.)	☐	☐
6.	Lungs, chest and breasts	☐	☐
7.	Heart (include estimate of cardiac function)	☐	☐
8.	Vascular system (include varicosities)	☐	☐
9.	Abdomen and viscera (include hernia)	☐	☐
10.	Ano-rectal and pilonidal	☐	☐
11.	Endocrine system	☐	☐
12.	Genito-urinary system	☐	☐
13.	Upper extremities	☐	☐
14.	Lower extremities (include feet)	☐	☐
15.	Spine, other musculoskeletal	☐	☐
16.	Skin and lymphatic (include acne)	☐	☐
17.	Neurological system	☐	☐
18.	Psychiatric (specify any personality deviation)	☐	☐
19.	If female, give menstrual history—specify medication		

Doctor, do you ...	**yes**	**no**
... see any signs of emotional instability during the examination?	☐	☐
... know of any drugs the student is allergic to?	☐	☐
If so, which ones?		
... have any special instructions for health care providers while the student is in school?	☐	☐
Is the student on any medication?	☐	☐
If so, which ones?		

Use the reverse side if needed to explain all 'yes' answers above and/or to use for additional comments.

Required for admission

Tuberculin test (**in past three months**) Date _____
Mantoux only Neg. _____ Pos. _____
If positive, needs chest X-ray.

Immunization history
Last booster—month and year

Diphtheria _____ 1st M.M.R. _____
Tetanus _____ 2nd M.M.R. _____
Polio _____ H.B.V. (recommended) _____

_____ M.D. _____
Signature of physician Please print, stamp or type name

Doctor: Please mail form directly to AMBS at the address above.

_____
Street address City State Postal code Country