**Health Check Card**

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| --- | --- | --- | --- | --- |
| Name |  | M / F | STUDENTNO. |  |

|  |  |
| --- | --- |
| 1. Do you get sick easily?
 | YES / NO |
| If so, please give details. |  |
| 2. Do you catch a cold easily? | YES / NO |
| If so, what kind of symptoms do you have?What medicine do you take/ Are you taking now? |  |
| 3. Do you get an upset stomach easily? | YES / NO |
| If so, what kind symptoms do you have? What medicine do you usually take/are you taking now? |  |
| 4. Do you get anemia easily? | YES / NO |
| 5. Are you a vegetarian? | YES / NO |
| If so, what do you do? |  |
| 6. Do you find it hard to sleep in a new environment? | YES / NO |
| 7. Do you have any allergies? | YES / NO |
| Food Allergy | What? |  | measure?  |  |
| Medicine Allergy | What? |  | measure? |  |
| Other | What? |  | measure? |  |
| 8. Have you ever had a serious illness or are you ill now? | YES / NO |
| Name of illness |  |
| Since when |  |
| Present condition |  |
| Medicine you are taking |  |
| Measures you take |  |
| 9. Do you ever feel unstable when your environment changes? | OFTEN / SOMETIMES/ RARELY |
| If you answered OFTEN or SOMETIMES then please write about how you deal with it. |  |
| 10. Are there any other medical conditions or instructions you have received from your doctor? |
|  |  |  |

Date:

I hereby declare that the statement is true and correct. Signature: