KGSP Medical Declaration Form

برنامج جامعة الملك عبدالله للعلوم والتقنية للطلبة الموهوبين
KAUST GIFTED STUDENT PROGRAM

NAME (Last, First Name)					CITY, COUNTRY OF RESIDENCE :		
AGE	GENDER	HEIGHT (m)	WEIGHT (KG)	BMI	COLOUR OF EYES	COLOUR OF HAIR	DATE OF BIRTH (mm/dd/yyyy)
DISTINGUISHING MARKS AND SCARS							

Please check the appropriate column and provide an explanation for any YES answers if you have or have had the following complaints or symptoms in the last 5 years. ("Yes" answers may also require additional information from treating physician).

CARDIOVASCULAR SYSTEM			
	Complaints/Symptoms	**Yes**	**No**
1	Chest pain - at rest		
	- with exercise		
2	Shortness of breath - at rest		
	- with exercise		
3	Swelling of ankles		
4	History of heart failure		
5	History of 'Heart Attack'		
6	Abnormal heartbeat or rhythm		
7	Implantable device (pacemaker, ICD..etc)		
8	Other		

GENITOURINARY			
	Complaints/Symptoms	**Yes**	**No**
9	Urinary problems		
10	Blood in urine		
11	Kidney stones		
12	Painful urination		
13	Abnormal discharge		
14	Prostate problems		
15	Menstrual problems		
16	Other		

RESPIRATORY SYSTEM			
17	Chronic Cough		
18	Spitting of blood		
19	Night sweats		
20	Frequent chest infections		
21	Wheezing / Tight chest		
22	Asthma		
23	Blood clot in the lungs (Pulmonary Embolus)		
24	Other (lung diseases)		

MUSCULOSKELETAL			
25	Muscular weakness		
26	Paralysis/ Polio		
27	Pain in the extremities		
28	Swollen joints		
29	Joint pain		
30	Back pain		
31	Disc problems		
32	Other (Musculo-Skeletal)		

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GASTROINTESTINAL TRACT

	Complaints/Symptoms	Yes	No
33	Unintentional Weight loss		
34	Weight gain		
35	Chronic abdominal pain		
36	Chronic constipation		
37	Diarrhea (Frequent)		
38	Difficulty in swallowing		
39	Gall bladder disease/ intolerance to fats		

	Complaints/Symptoms	Yes	No
40	Chronic Liver Disease		
41	Irritable bowel disease		
42	Blood in stools or black tarry stool		
43	History of Gastric Ulcer		
44	Other		

ENDOCRINE/GLANDULAR

	Complaints/Symptoms	Yes	No
48	Thyroid disease		
49	History of Diabetes, if "Yes" Is it controlled by (Please Mark) Diet Oral medication Insulin		
50	Other (Endocrine/Glandular)		

NEUROLOGICAL

	Complaints/Symptoms	Yes	No
51	Seizures/Epilepsy		
52	Recurrent headaches		
53	Migraines (state frequency and treatment)		
54	Co-ordination difficulties		
55	Memory problems		
56	Abnormal movements (Parkinson's)		
58	Dizziness		
59	Other (Neurological)		

EYES, ENT

60	Impaired vision		
61	Cataracts		
62	Discharge from ears, nose		
63	Chronic hoarseness		
64	Hearing Loss		
65	Other (Eyes, Ent)		

SKIN

66	Eczema		
67	Psoriasis		
68	Rashes		
69	Skin Cancer (melanoma, basal cell..etc.)		
70	Allergies (specify)		
71	Other (Skin)		

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MENTAL/PSYCHIATRIC			
72	Anxiety Disorder		
73	Personality Disorder		
74	Bipolar Disorder		
75	Psychotic Disorder		
76	Depression		
77	Other (Mental/Psychiatric)		

MISCELLANEOUS			
78	Do you Smoke? If "Yes", Number of cigs/day _____		
79	Do You Consume Alcohol? If "Yes", Number of Glasses Per day ____		
80	Ever been refused employment insurance or military service for health reasons?		

PRIOR DIAGNOSES

Have you ever been diagnosed with any of the following? If "Yes" please attach detailed medical report

	Complaints/Symptoms	Yes	No
81	Hepatitis A		
82	Hepatitis B		
83	Hepatitis C		
84	HIV		
85	Tuberculosis		
86	Cancer or Malignancy of any sort		
87	Stroke (CVA)		
88	Crohn's disease/Ulcerative Colitis		

	Complaints/Symptoms	Yes	No
89	Chronic Hypertension		
90	Heart Disease		
91	Asthma		
92	Fibromyalgia		

GENERAL QUESTIONS			
		Yes	No
GQ1	Have you ever consulted a specialist in the last 2 years? (If yes, please attach a detailed medical report from each specialty).		
GQ2	Have you been advised that surgery is necessary for an existing condition? (If yes, please attach a detailed medical report from physician).		

MEDICATIONS	
Please list any prescription medication being taken presently and their indication:	
P1	

P2	
P3	
P4	
P5	
Please list any prescription medications taken in the last year:	
M1	
M2	
M3	
M4	
M5	
Please list any other medications taken regularly or occasionally (including supplements, vitamins, herbs..etc.) Not Listed Above.	
M6	
M7	
M8	
M9	
M10	

HOSPITALIZATIONS

Please list last 5 hospitalizations within the last 10 Years (if any)

	Diagnosis	Length of stay (days)	Result of treatment/outcome
H1			
H2			
H3			
H4			
H5			

EXPLANATION OF "Yes" ANSWERS

NOS.	EXPLANATION	Attached Medical Report	
		Yes	No

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Declaration:
I, certify that the above information is true and accurate to the best of my knowledge. I understand that deliberate omission or falsification of any information on this questionnaire may be grounds for

_____	_____	_____
Name of student	Signature	Date