

# INTERNATIONAL UNIVERSITY OF HEALTH AND WELFARE

## Self-Declaration Health Questionnaire

\*This form must be submitted by all applicants.

\*If there is nothing to fill in, please write "N/A" in the top field of each table.

Katakana		Gender	Date of Birth
Name	Family Name      First Name	M / F	Year      Month      Date      Age

Medical History				
Please fill in the fields below if you have or have had any serious illness or injury.				
Diagnosis (age of onset)	Department	Surgery	Hospitalization (length)	Current Condition (circle one)
(age    )		Yes / No	Yes / No (    yr    mo)	<ul style="list-style-type: none"> <li>•Treated (age    )</li> <li>•Currently being treated</li> </ul>
(age    )		Yes / No	Yes / No (    yr    mo)	<ul style="list-style-type: none"> <li>•Treated (age    )</li> <li>•Currently being treated</li> </ul>
(age    )		Yes / No	Yes / No (    yr    mo)	<ul style="list-style-type: none"> <li>•Treated (age    )</li> <li>•Currently being treated</li> </ul>
(age    )		Yes / No	Yes / No (    yr    mo)	<ul style="list-style-type: none"> <li>•Treated (age    )</li> <li>•Currently being treated</li> </ul>
Disease that is currently being taken				
Medicine you are currently taking				

If you have a visual or an auditory impairment, please fill in the details. E.g., "color blindness (monochromacy)," "hardly able to hear (hearing level __dB)," "no trouble with daily activities with hearing aids"	
Visual impairment (eye sight, visual field, color vision)	
Auditory impairment	

Please fill in the details if you request any special accommodations during the examinations as well as while you are in school, including clinical training.