OFFICE OF THE REGISTRAR, ACADEMIC, RESEARCH AND STUDENT AFFAIRS

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MEDICAL EXAMINATION FORM

PERSONAL HISTORY

Surname:…….. Other names:……REG NO……

Date of birth……Place of birth……

Next of Kin ……..……Relationship:……Address:……Tel. No:……...

1. SOCIAL HISTORY (Please indicate 'x' where appropriate)

Alcohol: YES…….NO……..
HOW OFTEN if yes)…….

Tobacco: YES…… NO…….
HOW OFTEN (if yes)
……. Regular doctor's medication: YES……..NO……. Which one……. History of mental illness:
NO……..YES……Give Details……
…… Have you been suspended from school? NO……YES……give details……
…… Do you suffer from any chronic illness? NO……..YES…….. if yes, which one:
( ) Diabetes, ( ) Hypertension, ( ) Tuberculosis, ( ) Hepatitis, ( ) sickle cell disease, ( ) leukaemia

Have you had any of these symptoms for more than one week?
( ) fever, ( ) Cold Chills, ( ) Weight Loss, ( ) Diarrhoea, ( ) Vomiting.

Do you have any known food or drug allergy? If Yes,

Specify
……

2 FAMILY HISTORY

Do any of your relatives suffer from?

( ) High blood pressure ( ) Diabetes, ( ) Heart Disease, ( ) Allergies, ( ) Mental illnesses, ( ) Epilepsy, other, please specify……

3 GENERAL EXAMINATIONS (To be examined in a government hospital)

General appearance: …….. Weight:…….

Height ……Respiratory System: inspiration……

Expiration……..

Cardiovascular System: pulse ……/mm B/P. Heart sounds…….

L/E…….. Genitourinary…….

Ears/Nose/throat…….

Skin……Sight…….... Sight retraction R/E

……..

4 LABORATORY EXAMINATION (Please attach lab, Reports)

Heamogram E.S.R V.D.R.I. Blood group……

Chest X-ray P/A (let your doctor decide if it's necessary) attach only radiologist report. Urinalysis (PT for females)…… Mantoux test (PPC)…….

5 FOR DOCTORS USE ONLY (Official stamp should be included)

Doctor's Name……. Signature…….

Qualification……. Date……

6 PERSONAL DECLARATION

I hereby consent to offer this information to any medical authority as deemed necessary to effect quick treatment.

Student'sName……..ID/PASSPORT/BIRTH CERTIFICATE NUMBER……SIGN……..DATE……..