MEDICAL EXAMINATION REPORT FOR INTERNATIONAL STUDENT

UNIVERSITI SAINS MALAYSIA

Affix passport size photo here

PLEASE USE CAPITAL LETTERS

SECTION 1 (TO BE COMPLETED BY CANDIDATE)

(PART A)

FULL NAME (AS IN PASSPORT)

PASSPORT NO.

NATIONALITY

DATE OF BIRTH

D D M M Y Y

AGE

CONTACT NO.

ACADEMIC YEAR

/

PROGRAMME

☐ MASTER ☐ DOCTORATE

GENDER

☐ MALE ☐ FEMALE

MARITAL STATUS

☐ SINGLE ☐ MARRIED

SCHOOL / CENTRE / INSTITUTE

NEXT OF KIN (RELATIVES)

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1

(PART B) - Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illness.

• Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
3. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illness					

Current medication (Long term)

_____ _____

_____ _____

IMMUNISATION HISTORY (where applicable)	DATE IMMUNISED				
1. Yellow Fever*					
2. BCG*					
3. Meningitis (Quadrivalent)*					
4. Hepatities B*					
5. Others					

I hereby certify that the information given above is true. I understand that my registration will be rejected if there is any false information given.

_____ _____

Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST: NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEM EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (Including fundus copy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIAL ORIFICES			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

To be filled by examining doctor

1. URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

** International candidates are required to conduct all the above tests.*

2. BLOOD TEST (Please attach all the original lab report)		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

** International candidates are required to conduct all the above tests.*

3. CHEST X-RAY INFORMATION		
CHEST X-RAY NO.		
DATE TAKEN		
PLACE TAKEN		
REPORT		

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR
Please tick (√) in the appropriate box

I certify that I have on this date _____ examined

Mr. / Ms. _____

Passport No. _____ and found him / her: -

☐ **IN GOOD HEALTH**

☐ **HAVING THE FOLLOWING MEDICAL COMPLICATION(S)** (Please State)

_____

_____

_____

☐ **UNDERGOING TREATMENT FOR:** (Please State)

_____

_____

_____

Date _____

Signature of Doctor _____

Name of Doctor _____

Qualification _____

Hospital / Clinic _____

Registration Number _____

Official Stamp _____

Remarks by University / College Official