umma university
Fostering Knowledge and Innovation

OFFICE OF THE REGISTRAR, ACADEMIC 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 Below…………………………………………………………………………………
……………………………………………………………………………………………
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, ( ) leukemia
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……………………………………………………………………………………

Others:……………………………………………………………………………………
……………………………………………………………………………………………
…………………………………………………………………………………………....

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………………………….

Genito Urinary……………………………………………………………………………..

Ears/Nose/threat…………………………………………………………………………….

Skin…………………………………………………Sight…………………………………...

Sight retraction R/E …………………………………... L/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's

Name……………………………………..Signature…………………Date……….....................