UNIVERSITI KEBANGSAAN MALAYSIA The National University of Malaysia	UKM-SPKP-JP-PK06-BO05	No. Semakan: 00	Tarikh Kuatkuasa: 01/05/2012
	MEDICAL EXAMINATION FORM		

CONFIDENTIAL

PROGRAM: _____

UNIVERSITI KEBANGSAAN MALAYSIA

HEALTH DECLARATION AND MEDICAL EXAMINATION FORM
FOR STUDENT APPLYING FULL-TIME COURSE FURTHER EDUCATION

PERSONAL DETAILS

Name:		I.C. No:
Date of Birth:	Sex:	Marital Status:
Home Address Contact No. (Hp/H)		
Name, relationship and address of next kin: Contact No. (hp/h):		

HEALTH DECLARATION (to be completed by student)

Have you ever suffered and of the following conditions?

ILLNESS	YES	NO
Psychiatric illness/(sakit jiwa)		
Epilepsy/(sawan)		
Migraine/(migraine)		
Hysteria (hysteria)		
Allergic Rhinitis/(resdung)		
Asthma/(lelah)		
Tuberculosis (PTB)/(batuk kering)		
Hypertension (HPT)/(darah tinggi)		
Diabetes Mellitus (DM)/(kencing manis)		
Heart Diseases/(penyakit jantung)		
Thyroid Diseases/(penyakit tiroid)		
Kidner Diseases/(penyakit buah pinggang)		
Gastric/(penyaking gastric)		
HIV/AIDS		
Cancer (Barah)		
Venereal Diseases/(penyakit kelamin)		
Leukemia/(leukemia)		
Hepatitis/(hepatitis)		

Please State/(Sila Nyatakan)

Other illnesses: _____

Operation/Surgical: _____

Allergic: _____

Family Medical History: _____

Disability/Handicap: _____

I herby certify that the above information is true and complete, and agree that any misrepresentation or deliberate omissions of a material fact on the form may result in my not being permitted to enter a program, or may result in termination. I hereby grant Human Resource Development Section, Universiti Kebangsaan Malaysia, permission to share information contained in my Medical Examination form.

Date: _____ Signature: _____

MEDICAL EXAMINATION (to be completed by certified physician)

(Physician must complete all questions and give additional comment where necessary. Kindly note that physician is responsible for the information, suggestions and recommendation regarding the student's health given in this form).

Student Name:	Date of Birth:

PHYSICAL EXAMINATION

Weight:	Height:
Blood Pressure:	Pulse:
Skin:	Color:
Eye Vision Test (RT)	Eye Vision (LT):

Are there abnormalities of the following systems? If yes, describe fully using additional sheet if necessary.

SN	SYSTEMS	NORMAL	ABNORMAL	COMMENT
1	Skin			
2	Head			
3	Eyes			
4	Ears			
5	Nose			
6	Mouth			
7	Neck			
8	Chest			
9	Breasts			
10	Cardiovascular			
11	Syncope			
12	Chest Pain			
13	Heart Murmur			
14	Abdomen			
15	Genitourinary			
16	Extremities			
17	Neurologic			

URINE TEST

NAD		WBC		RBC		PROTEIN		GLUCOSE	

HEPATITIS TEST

POSITIVE		NEGATIVE	

PREGNANCY TEST

POSITIVE		NEGATIVE	

Is the student now under treatment for any physical or emotional condition?

_____

Do your have any recommendations for the health care of this student?

_____

By history and physical examination, is this student a carrier of any communicable disease?

_____

Date: _____ Physician Signature: _____

Note: In completing this form, particular attention should be paid to following points:

(a) X-ray of chest to rule out any tuberculosis or chronic pulmonary disease: Where the film is entirely normal it needs not be forwarded, but if any abnormality is noted the film should be sent with this report.

(b) Kidneys: no evidence of renal lesion should be present.

(c) Eyesight – severe errors of refraction should be not be passed as these should only give trouble during the years of study.

(d) Hearing – deafness should be considered a definite bar