

DIVINE WORD UNIVERSITY

MEDICAL REPORT

SURNAME	Given Names	Date of birth
		_____ / _____ / _____ <i>Day Mon Yr</i>

Family History – Please give details of any significant medical problems of your parents, brothers, sisters.

THIS FORM AND THE INFORMATION CONTAINED IN IT ARE CONFIDENTIAL. Its only purpose is to ensure that you do not have a medical condition that prevents you from doing your best in your studies and participating fully in student life. You should read carefully the following questions before writing in the answers. All questions should be answered before signing this section in front of your doctor or examining medical officer

QUESTIONS	ANSWER	EXPLANATORY NOTES
	YES/NO	
1. <i>Have you or anyone in your family had tuberculosis?</i>		<i>Who has had it?</i>
2. <i>Have you had a persistent cough of spit up blood?</i>		<i>When?</i>
3. <i>Have you ever had asthma, problems breathing, shortness of breath or fainted?</i>		<i>Give details</i>
4. <i>Have you had epilepsy or fits?</i>		<i>When was the last time? What was your treatment?</i>
5. <i>Have you had malaria or dengue fever?</i>		<i>When was the last time? What was your treatment?</i>
6. <i>Have you had a stomach, intestinal tract or urinary tract infection?</i>		
7. <i>Do you have constant diarrhoea or constipation?</i>		<i>Give details</i>
8. <i>Do you get severe headaches?</i>		<i>When did you last have your vision checked?</i>
9. <i>Do you have problems hearing?</i>		<i>Give details</i>
10. <i>Have you had a skin infection?</i>		<i>When? On what part of your body?</i>
11. <i>Have you broken any of your bones?</i>		<i>Which ones?</i>
12. <i>Have you ever had an operation?</i>		<i>When and for what?</i>
13. <i>Are you allergic to anything?</i>		<i>What? What is the reaction?</i>
14. <i>If you are female, have you had any menstrual problems?</i>		<i>Give details</i>
15. <i>Have you had an STD – a sexually transmitted disease?</i>		<i>If yes, what treatment were you given?</i>

Student's signature _____ *Date:* _____

CONFIDENTIAL

MEDICAL OFFICER'S REPORT

1. <i>Student's appearance, as regards robustness and activity.</i>	
2. <i>Height</i>	<i>Cm.</i>
3. <i>Weight</i>	<i>Kg.</i>
4. <i>After examination are you perfectly satisfied as to the clinical efficiency of the heart? If no, give your reason in full</i>	
5. <i>Blood pressure</i>	<i>Systolic.....millimetres. Diastolic.....millimetres</i>
6. <i>After examination, are you perfectly satisfied as to the clinical efficiency of lungs? If not, give your reasons.</i>	
7. <i>Is there any evidence of abdominal infection? If so, give particulars</i>	
8. <i>Is there any defect in hearing or speech? If so, give particulars.</i>	
9. <i>Is there any nasal, throat or sinus infection? If so, give particulars</i>	
10. <i>Is there any visual defect or disease of the eyes?</i>	<i>Visual acuity: R L Colour Vision:</i> <i>Does the student need glasses: YES NO</i>
11. <i>Does the student possess the normal use of all limbs?</i>	
12. <i>Is there any evidence of enlarged glands, running sores, ulcers, defects in joints?</i>	
13. <i>Is there any evidence of dental defects?</i>	
14. <i>Is there any other health conditions which should be mentioned? If so give details.</i>	
15. <i>Is there any medical condition that would prevent or affect this student from undertaking normal academic work and classroom participation? If so, give details</i>	
16. <i>Is there any medical condition that would prevent this student from participating in sports? It so, give details.</i>	
17. <i>Is there any medical condition that would prevent this student from participating in the Institute's community services programme – cleaning grounds, dormitories and classrooms, cutting grass, gardening, cooking, etc. If so, give details</i>	
18. <i>Is there any medical condition which requires a special diet? If so, give details.</i>	

Chest X-ray report:

MEDICAL OFFICER'S NAME

SIGNATURE

DATE