



Divine Word University

PO Box 483, Madang, Madang Province, Papua New Guinea
Tel: (675) 422 2937 Fax : (675) 422 2812

STUDENT MEDICAL HISTORY AND EXAMINATION RECORDS

Medical in Confidence

Note: The information contain in this form are confidential. Its sole purpose is to ensure that you do not have a medical condition that prevents you from doing your studies and fully participate in student activities. Read carefully the instructions then complete the Identification Data and Family History correctly. All questions should be answered before signing in the presence of the examining medical doctor.

1. IDENTIFICATION DATA

Given Name

Surname

Program

Year

Student ID

Date of Birth

Mobile Number

Email Address

Last School Attended

Province of Origin

Home Address

In case of Emergency who to contact

Name

Phone Number

Email Address

Other contact details

Mother's Province of Origin

Father's Province of Origin

Previous Occupation (s) if any

Are there any significant health related issues you would like to mentioned

2. Family History (including yourself)

Question	Answer (Yes/No)	Give Details of the problem
Are there Tuberculosis, prolong coughing, coughing up blood, loss of weight, gland swelling in the neck region in you family?		
Are there shortness of breath or problems with breathing such as asthma in your family?		
Are there any epilepsy, fits, sudden loss of consciousness, stroke or people with disability in your family		
Are there diabetes, high blood pressure, heart diseases, rheumatic fever, persistent headaches or obesity in your family?		
Are there difficulty during reading such as headaches or looking at distant objects?		
Are there stomach pains, vomiting dark blood with painful abdomen or difficulty in passing stool? (Constipation)		
Are there lower abdomen pain, pain when passing urine or seen discharges?		
Are there any trauma or accidents in family such as broken bones or that require surgery?		
Are there any allergy, such as skin rash, or running nose or some difficulty in breathing?		
For females only: Are there any problems with period such as pains, irregular or heavy flow?		
Have you or a family member been admitted to a Health Centre or a Hospital for a medical or surgical conditions		
Are there any hearing or dental problem in you family		
Do you consider yourself to be well and healthy? If so, are you overweight, underweight or underweight?		

Should you have any further comments you would like to make, use the space below

Student's Signature

Date

Medical Doctor's Report

Body Mass Index	Height (Meters)	<input type="text"/>	Weight (Kg)	<input type="text"/>	BMI	<input type="text"/>
Vitals	Systolic/Diastolic	<input type="text"/>	Pulse (Rate)	<input type="text"/>	Pulse (RA)	<input type="text"/>
Visual Acuity	Right	<input type="text"/>	Left	<input type="text"/>	Color Vision	<input type="text"/> Normal <input type="text"/> Abnormal
Urinalysis	Appearance	<input type="text"/>	Protein	<input type="text"/>	Student will require glasses	<input type="text"/> Yes <input type="text"/> No <input type="text"/> Sugar

General Observation: Robustness and Activity

Systemic Examination

Comments

Head and Neck including speech, hearing, eye movement and dental.	
Chest movement, the trachea and lungs.	
Cardiovascular system: the JVP and the heart.	
Abdominal examination.	
Extremities; spin, joint pain and swelling	
Uro-genital system and kidney	

Are there other condition (s) or comments you would like to mentioned.

Requires follow up (previous record or referral)	
Students activities on campus, sports etc	
SPECIAL DIET	

Doctors Final Comments

Further test require
(X-ray, FBC, Malaria slides etc)

 Medical Officers Name

 Signature

 Date

