Divine Word University

STUDENTS MEDICAL HISTORY AND EXAMINATION RECORD

Medical in Confidence

Attach Passport Photo

NOTE: This form and the inofrmation contained in it are confidental. It's sole purose is to ensure that you do not have a medical condition that prevents you from doing your studies and participating fully in student activities. Please take time to read carefully the instructions then fill in the identification data before proceeding to the question and fill in your answers in the space provided besides the questions. All questions should be answered before signing in the presence of the examining medical doctor.

1 IDENTIFICATION DATA

SURNAME

OTHER NAMES

Student ID:

Gender Male /Female

Date of Birth Day Month Year

Your Mobile Number

Email address

Last High School Attended

Province of Origin

Your Home Address

In case of Emergency who to contact

Name

Phone Number

E mail Address

Other contact details

Mothers Place of Origin

Fathers Province of Origin

Previous Occupation (s) if any (e.g)

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

2 Family History (*including yourself*)

Questions	Answer Yes/No	Give more detail of the problem
Are there Tuberculosis, prolonged coughing, coughing up blood, loss of weight, gland swelling in neck region in your family		
Are there shortness of breath or problems with breathings 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, persistant headaches or obesity in your family		
Are there difficulty during reading such as headaches or looking at distant objects.		
Are there stomach pains, vomiting darkblood with painful abdomen or difficulty in passing stool (constipation)		
Are there lower abdominal pain, pain when passing urine or seen discharges		
Are there any traum or accidients 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 breating		
For females only: Are there any problems with periods 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 condition?		
Are there any hearing or dental problem in your family.		
Do you consider your self 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

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Body Mass Index	Height (metres)		Weight (kg)		BMI		
Vitals	Systolic/Diastolic		Pulse (Rate)		Pulse (RA)		
Visual Acuity	Right		Left		Colour vision	Normal / Abnormal	Student will require glasses Yes No
Urinalysis	Appearance		Protien		Sugar		

General Observation: Robustness and activity

Systemic Examination	Comments
Head and Neck including speech, hearing, eye mov't and dental.	
Chest movements, the trachea and the lungs	
Cardiovascular system: the JVP and the heart	
Abdominal examination	
Extremities: spine, joint pain and swelling	
Uro-genital System and Kidney	

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

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

Doctors Final Comments

Further tests required (*X ray, FBC, Malaria slides etc*)

Medical Officers Name _____ Signature _____ Date _____