Passport

Photograph

STUDENT ENTRANCE MEDICAL EXAMINATION

Students are required to complete PART I of this form and leave PART II and PART III to be completed by a medical officer at the university Health Services U.I. The form should be returned to the Health Service.

PART I (to be filled by student) (clarify unclear aspects with the Doctor)

Surname: ……. Other Names: ……..……

Age: ……Date of Birth: …… Sex: …….. Marital Status: …….

Nationality: …….... State: ……..... Faculty…..…….Department: …….

Matric No: …… Tel No: ……

For Emergencies: Name of Contact person:..……

Address of Contact person: ……..……..

Telephone No: .……

1. Have you ever been admitted in hospital? Yes/No

If so, please state reason for admission, name of hospital and date: ……..

…….

2. History of previous Surgeries/Operations Yes/No

If yes, state surgery, year and hospital ……

……..

3. Are you on any medication(s)? ..... If so, please state drug and dosage ……..…….

4. Do you suffer from or have you suffered from any of the following

a.	Tuberculosis	Yes/No	f.	Diabetics	Yes/No
b.	Asthma	Yes/No	g.	Hypertension	Yes/No
c.	Peptic Ulcer Disease	Yes/No	h.	Seizures/Convulsions	Yes/No
d.	Sickle cell disease	Yes/No	i.	Mental illness	Yes/No
e.	Allergies	Yes/No	j.	Others: ……..	

5. If the answer to the above is yes, please give detail with dates:

……

6. Do you know your Genotype and Blood group Yes/No

7. If yes state your Genotype …….. Blood Group ……..……

8. If there are any other details of your medical history not covered, please state……

……

9. Has any one of your family suffered from Tuberculosis ……..Seizures/Convulsions……

Hypertension …….. Diabetics ……Mental illness ……

10. Do you react to any drug(s) Yes/No if yes state the drugs(s) ……

11. Have you been immunized against any of the following:

Hepatitis B	Yes/No	Date ……
Tetanus	Yes/No	Date ……
Yellow fever	Yes/No	Date ……
C.S.M	Yes/No	Date ……
Others		Date …….

12. Do you currently use tobacco products such as cigarettes, snuff etc? Yes ☐ No ☐

13. If yes, on an average, how many cigarette sticks do you smoke per day? …… cigarettes/day

14. For how long have you used tobacco products e.g. cigarettes, snuff etc? …….

15. How old were you when you started using tobacco products? …….. years old

16. Do you have someone at home/school who smokes when you are present? Yes ☐ No ☐

17. Do you currently consume any alcohol? Yes ☐ No ☐ (*if no, go to 20*)

18. If yes, on an average, what is the frequency of consumption?

Equal to or more than 5 days per week ☐

1-4 days per week ☐

1-3 days a month ☐

Occasionally

19. If yes, how many bottles/cans do you consume per day? .....

20. If no, have you ever consumed alcohol in any form? Yes ☐ No ☐

21. How old were you when you started consuming alcohol? ……..... years old.

22. During the past 1month, other than your regular activity, did you participate in any physical activities or exercises such as jogging, tennis, golf, gardening or walking for exercise? Yes ☐ No ☐ if no go to 25)

23. If yes, which exercise did you engage in……For how long (duration)? .....……

24. If yes, how often do you engage in this kind of exercise?

a. Daily ☐ b. 1-3 times per week ☐ c. Once weekly d. 1-3 times per month ☐

25. In a typical week, do you eat/drink the following:

	Yes	No	No. of times
Fruits			
Uncooked vegetables e.g carrots, cabbage			
Cooked vegetables			
Pastries			
Fried foods			
Soft drinks			
Red meat e.g. beef			

Date:…… Signature:……

PART II

Height……(in meters only) Weight……kg

Visual acuity:

Without glasses R.6/ L.6/

With glasses R.6/ L.6/

Hearing

Left

Right

Eyes

Ears

Pharynx

Teeth

Lymphatic Glands

Circulatory System

Heart Rate

Rhythm

Sounds

Blood Pressure

Respiratory System

Lungs

G.I.T

Liver

Spleen

Hernia

C.N.S

Cognitive functions

Orientation

Memory

Intelligence

Pulpillary reflexes

Spinal reflexes

Any other observation? ……..

PART III

URINE

Albumen

Sugar

CHEST X-Ray

Film No…….

Date……

Result……..…..

Date…… Name of Medical Officer……

Signature……

University Health Service