DOMINION UNIVERSITY
CITY OF FAITH, KM 24, IBADAN-LAGOS EXPRESS WAY
OYO STATE, NIGERIA

STUDENT MEDICAL EXAMINATION FORM

Students are required to complete PART I of this form with the help of a Doctor and have Part II completed by a Medical Officer. The form should then be returned to the University Clinic. The information supplied will be treated in strict confidence.

PART I (To be filled by Student)

Surname: _____ Other Names: _____

Age/Next Birthday: _____ Sex: _____ Married or Single:_____

Nationality: _____ Place of Birth: _____

Department:_____ Course Option:_____

Name of Parent:_____ Phone No. of Parent:_____

Name of Next of Kin:_____

Address of Next of Kin:_____ Phone No:_____

Please underline your answer as applicable.

a. Would you say your health is good/fair/poor?
b. Have you ever been admitted as an in-patient into a hospital?
If so, please state reason(s) for admission, name of the hospital and date.

_____

_____

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

(i) Tuberculosis Yes/No
(ii) Mental or Nervous Disease Yes/No
(iii) Passing blood in the Urine Yes/No
(iv) Any disease of the heart - Yes/No
(v) Any Respiratory disease Yes/No
(vi) Any Veneral disease of Kidney or Bladder Yes/No
(vii) Any disease of Ear, Nose and Throat Yes/No
(viii) Any disease of the Digestive System - Yes/No
(ix) Allergies e.g Asthma, Skin Disease Yes/No
(x) E.g Peptic Ulcer, Hernia, Pile, e.t.c Yes/No
(xi) Any Disease of the Intergumentary (Skin) System . Yes/No

If the answer to any of the above is Yes, please give details with date(s)

_____

_____

d. If there are any other relevant details of your Medical history not covered by the above questions, please give details.

_____

_____

e. Is your family a healthy one?
Has any member of your family suffered from Tuberculosis, insanity or Mental disease?

f. Have you been immunized against the following?

Yellow Fever - Yes/No Date: _____

Small Pox - Yes/No Date: _____

Tetanus - Yes/No Date: _____

Signature of Student:_____Date: _____

PART II (To be completed by a Medical Doctor)

Height:_____ m _____ cm:_____Weight: _____

Kg: _____ g: _____

Visual acuity Snellen

Without glasses R 6/ L 6/

With glasses R 6/ L 6/

HEARING

Left: _____ Heart: _____

Right: _____ Blood Pressure: _____

Eyes: _____ Respiratory System: _____

Pharynx: _____ Lungs: _____

Teeth: _____ Liver: _____

Lymphatic glands: _____ Spleen: _____

Skin: _____ Hernia: _____

C.N.S

Papillary Reflex

Spinal Reflex

URINE	**STOOL**	**BLOOD**
- Ab	- Occult Blood	Hb: _____
- Sugar	- Microscope	Blood Group:_____
- Protein	- Ova or Cyst	Genotype:_____
		VDRL Test:_____

CHEST X-RAY

Film No: _____ Hospital: _____

Attach Radio-logist's Report_____

Any other observation:_____

Remarks: _____

Date: _____

_____ _____

Medical Officer's Name, Signature & Stamp **Hospital Address:**

**Snellen or similar test should be used*