DECCA COLLEGE OF HEALTH AND ALLIED SCIENCES (DECOHAS)

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STUDENT'S MEDICAL EXAMINATION FORM

To the Medical Officer:

.....

.....

REF: Mr/Mrs/Miss .....

PERSONAL HISTORY

Surname ..... Other names .....

Adm. No.....

Faculty / Department .....

Nationality..... Age..... Sex..... Marital Status.....

Please examine the above named as to his/her fitness for undergoing the studies.

Signature: ..... Date ..... 20.....

PAST MEDICAL HISTORY

Any experience of loss of consciousness YES/NO If Yes treatment.....

Any neurological deficit YES/NO, If Yes specify.....
Treatments .....

Any experience of Fits/Convulsion YES/NO, If Yes treatments .....

CHRONIC ILLNESSES

Diabetes Mellitus YES/NO, If Yes when diagnosed .....
Current status: On diet ☐ On medication ☐ On insulin ☐ Not controlled ☐

Cardiovascular conditions YES/NO, If Yes specify .....

Asthma YES/NO, If Yes how many attacks per months .....

Any mental illness YES/NO, If Yes On medications ☐ Not on medications ☐

Any allergy YES/NO, If YES specify ……

Tuberculosis YES/NO If Yes Cured ☐ On treatment ☐ Not on treatment ☐

Leprosy YES/NO, If Yes Treated ☐ On treatment ☐ Not on treatment ☐

Any other chronic disease(s) ……

PHYSICAL EXAMINATION

1. Height …… Weight……

2. Chest – Lungs……

Heart ……

BP ……

3. Abdomen

Organs ……

Other Mass ……

Pregnancy ……

4. Skin disease ……

5. Eyes: Conjunctiva ……

Pupils ……

Sight: without glasses Right …… Left ……

Sight: With glasses Right …… Left ……

6. ENT……

INVESTIGATIONS

a) ESR …….. WBC …….. B/S …….. Stool…….. Urinalysis ……..VDRL ……

b) Human Immunodeficiency Virus Test (optional) ……

Any Physical disability of the Prospective student plus the Doctors recommendations

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CONCLUSION

I have examined Mr./Mrs./Miss …….. and considered that he/she is **fit/not fit** to be enrolled as a student at DECOHAS.

Name ……..

Signature…….

Title …….. Designation ……..

Date ……

(Official Stamp)

This form must be filled with a registered medical officer