MEDICAL EXAMINATION REPORT FOR LOCAL / INTERNATIONAL STUDENT AND ACCOMPANYING PERSON

UNIVERSITI SAINS MALAYSIA

Affix passport sized photo here

International students are required to complete this form after arrival to Malaysia at USM Health Facilities Centres/USM Hospital/Malaysia Public Hospitals/Clinics only.

Local students can proceed for Medical Examination at any hospitals/clinics.

PLEASE USE CAPITAL LETTERS

SECTION 1 (TO BE COMPLETED BY CANDIDATE) (PART A)

FULL NAME (AS IN PASSPORT / IC)

PASSPORT NO.

IDENTITY CARD NO. (MALAYSIAN ONLY)

NATIONALITY

DATE OF BIRTH

D D M M Y Y

AGE

CONTACT NO.

ACADEMIC YEAR

PROGRAMME

☐ MASTER ☐ DOCTORATE / PHD

GENDER

☐ MALE ☐ FEMALE

MARITAL STATUS

☐ SINGLE ☐ MARRIED

SCHOOL / CENTRE / INSTITUTE

NEXT OF KIN (RELATIVES)

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1
(PART B) - Please tick (√) in the relevant box
Declaration of self and family illness. Explain in full if you or your family has any of the following illness.
• Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
3. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illness					

Current medication (Long term)

_______________________________ _______________________________

_______________________________ _______________________________

IMMUNISATION HISTORY (where applicable)	DATE IMMUNISED				
1. Yellow Fever*					
2. BCG*					
3. Meningitis (Quadrivalent)*					
4. Hepatities B*					
5. Others					

** Applicable for international candidates only.*

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

_______________________ _______________________

Date Signature of candidate

SECTION 2 - PHYSICAL EXAMINATION
To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : ______________________ m	BLOOD PRESURE :______________mmHg
WEIGHT : ______________________ kg	PULSE RATE : ______________ / min
VISION TEST : Unaided : (R) (L) Aided : (R) (L)	COLOUR VISION TEST: NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	**YES**	**NO**	**COMMENT**
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEM EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (Including fundus copy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIAL ORIFICES			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

To be filled by examining doctor

1. URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

** International candidates are required to conduct all the above tests.*
** Malaysian candidates are required to conduct tests for item a, b, and c only.*

2. BLOOD TEST (Please attach all the original lab report)		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

** International candidates are required to conduct all the above tests.*
** Malaysian candidates for Master of Medicine, Master of Surgery and Master of Pathology are required to conduct tests for item a, b, and c only.*
** Malaysian candidates for other programs are NOT required to conduct Blood Test.*

3. CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR
Please tick ($\surd$) in the appropriate box

I certify that I have on this date___________ examined Mr. / Ms.______________________________

IC / Passport No. _____________________________________ and found him / her: -

☐ **IN GOOD HEALTH**

☐ **HAVING THE FOLLOWING MEDICAL COMPLICATION(S)** (Please State)

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☐ **UNDERGOING TREATMENT FOR:** (Please State)

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Date _______________________

Signature of Doctor _______________________

Name of Doctor _______________________

Qualification _______________________

Hospital / Clinic _______________________

Registration Number

Official Stamp _______________________

Remarks by University / College Official