GUIDELINES TO FILL IN HEALTH EXAMINATION REPORT

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN **ENGLISH LANGUAGE.**
3. PLEASE WRITE IN CAPITAL LETTERS.
4. THIS FORM HAS 2 SECTIONS
    - SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATES
    - SECTION 2 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. PLEASE ATTACH ALL THE **ORIGINAL AND DETAIL LABORATORY** RESULTS AND THE RESULTS MUST BE REPORTED IN **ENGLISH.** IT MUST BE DONE WITHIN 2 MONTHS PRIOR TO REGISTRATION.
7. PLEASE BRING ALONG THE CHEST X-RAY FILM AND REPORT.
    a PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN **(IN ENGLISH)**
    b CHEST X-RAY MUST BE DONE **WITHIN 6 MONTHS** PRIOR TO REGISTRATION
8. UNIVERSITY HEALTH CENTRE CONCERNED HAS THE RIGHT TO **REPEAT** THE MEDICAL CHECK-UP SHOULD THERE BE **ANY DOUBT** OF THE MEDICAL REPORT. ALL COSTS INVOLVED WILL BE PAID BY THE CANDIDATES.
9. THE UNIVERSITY / COLLEGE RESERVES THE RIGHT TO REJECT ANY APPLICATION:
    (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
    (b) SHOULD THERE BE ANY EVIDENCE THAT APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

KEMENTERIAN PENDIDIKAN MALAYSIA

HEALTH EXAMINATION REPORT

Passport size photo (COMPULSORY)

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate)
(PART A)

FULL NAME (AS IN IDENTIFICATION CARD/KP)

IDENTIFICATION NO(I/C)

RACE

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL STATUS
SINGLE
MARRIED

ACADEMIC YEAR
/

SEMESTER

FACULTY

MATRIC NO.

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

RELATIONSHIP

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 illnesses.
* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		*IMMEDIATE FAMILY		If "Yes" please state. You are required to submit your medical history/report from your treating physician if you have sought consultation for any of the listed diseases/conditions
	Yes	No	Yes	No	
1. AIDS, HIV					
2. Hepatitis B/C					
3. Tuberculosis					
4. Drug addiction					
5. Congenital or inherited disorder					
6. Allergy					
7. Mental illness (depression,ocd,schizo,etc)					
8. Fits, stroke, other neurological disease					
9. Diabetes Mellitus					
10. Hypertension					
11. Heart or vascular disease					
12. Asthma					
13. Thyroid disease					
14. Kidney disease					
15. Cancer					
16. History of surgery					
17. Other illnesses/handicapped					

Current medication (Long term):

_____ _____

_____ _____

IMMUNIZATION HISTORY	DATE IMMUNIZED				
1. Yellow fever					
2. BCG					
3. Typhoid					
4. Meningitis (Quadrivalent)					
5. Hepatitis B					
6. Others					

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 PRESSURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR BLIND TEST : NORMAL / ABNORMAL

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

3. SYSTEMIC EXAMINATION			
ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
URINE FEME (DETAIL REPORT)		

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

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date _____ examined

Mr / Ms _____ Passport No. _____

and found him / her :-

☐ IN GOOD HEALTH

☐ FOUND TO HAVE (Please State)

_____

_____

☐ HAS MEDICAL PROBLEM (Please State)

_____

_____

_____

☐ IS UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification and : _____

Official stamp of Clinic

Remarks By University Official :