**NNAMDI AZIKIWE UNIVERSITY, AWKA**

**COLLEGE OF POSTGRADUATE STUDIES**

**STUDENT’S MEDICAL REPORT**

Passport Photograph

**Kindly complete Section A below and take the form to the University Medical Centre for Medical Test/Examination. Return the form (together with your files) to the Secretary College of Postgraduate Studies.**

**SECTION A**

|  |  |  |  |
| --- | --- | --- | --- |
| SURNAME:  |  | OTHER NAMES: |  |
| DEPARTMENT |  | FACULTY: |  |
| MARITAL STATUS: |  | NUMBER OF CHILDREN: |  |
| AGE:  |  | SEX: |  |
| PRESENT OCCUPATION: |  |
|  |  |  |  |

**PREVIOUS HEALTH CONDITION:**

|  |  |
| --- | --- |
| **(a)** | Have you suffered from or do you suffer from any of the following? |
| (1) | Tuberculosis | Yes/No |  | (6) | Diabetes | Yes/No |
| (2) | Hypertension | Yes/No |  | (7) | Peptic Ulcer | Yes/No |
| (3) | Epilepsy | Yes/No |  | (8) | Piles (Hemorrhoids) | Yes/No |
| (4) | Mental Illness | Yes/No |  | (9) | Gonorrhea or Syphilis | Yes/No |
| (5) | \*Heat in the Heart of Body | Yes/No |  | (10) | Heart Disease | Yes/No |

|  |  |
| --- | --- |
| **(b)** | If the answer to any in (a) is YES, please give details below and include other illnesses not mentioned. |
| **WHICH ILLNESS** |  | **DATE** & **DURATION** |  | **HOSPITAL ADDRESS** |
|  |  |  |  |  |
|  |  |  |  |  |
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**SECTION B (FOR DOCTOR’S USE)**

**RELEVANT EXAMINATION**

|  |
| --- |
| **GENERAL:** |
| Height in metres/cm (without shoes): |  | Weight in Kilograms (indoor close): |  |
|  |
| **VISUAL ACUITY:** |
| With Glasses: | R/6  | L/6  |
| Without Glasses: | R6 + Snellen Types |  |  |
| Left: |  |
| Right: |  |
| Condition of Ear Drum: |  |

|  |
| --- |
| **PULSE:** |
| At Rest: |  | B.P. |
| 25 Times on Each Leg |  |
| 2 Minutes after Exercise: |  |
| Heart Site of Apex Beat: |  |
| Cardiac Sound and Rhythm:  |  |

|  |
| --- |
| **ABDOMEN:** |
| Liver: |  | Epigastric Tenderness: |
| Spleen: |  | Hernia: |
| Any Other Masses: |  |
| Respiratory System: |  |
| Percussion Note:  |  |
| Character of Health Sound: |  |
| C.N.S. Pupillary Reflexes: |  |
| \*Spinal Reflexes: |  |
| Urine Albumen: |  | Sugar  | Deposit |
| Kahn Test |  |

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| **ANY OTHER COMMENTS BY THE DOCTOR** |
| Name of Doctor: |  |
| Qualification |  |
| Address |  |
|  |  |  |  |
|  |  | Signature  | Date: |

|  |
| --- |
| **COMMENTS BY THE UNIVERSITY PHYSICIAN** |
| Heart Test: | Date done:  |  | Result |  |
|  |  |
| M.M.R. X-ray: | Doctor’s Comments: |  |
|  |  |  |
|  |  |
|  |  |
|  |  |
|  | Signature of Doctor: |  |
|  | Date: |  |