IIUM HEALTH AND WELLNESS CENTRE
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA

HEALTH EXAMINATION REPORT
(for International Students)

PASSPORT SIZE PHOTO

INSTRUCTION: PLEASE FILL IN USING CAPITAL LETTERS
SECTION 1 (To be completed by candidates)
(PART A)

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY

CONTACT NUMBER

DATE OF BIRTH
D D M M Y Y

AGE

SEX
MALE
FEMALE

MARITAL STATUS
SINGLE
MARRIED

ACADEMIC YEAR
/

STUDENT ID

PROGRAMME OF STUDY

PROGRAMME CODE

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

FULL NAME (AS IN PASSPORT) & MATRIC NO.

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.
		Yes	No	Yes	No	
1	Congenital or inherited disorder					
2	Allergy					
3	Mental illness					
4	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 illnesses					

Current medication (Long term)

_____

_____

	IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1	Yellow Fever					
2	BCG					
3	Meningitis (Quadrivalent)					
4	Hepatitis B					
5	Others:					

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

…….. ……..

Date Signature of candidate

FULL NAME (AS IN PASSPORT) & MATRIC NO.

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT :_____m	WEIGHT :_____kg
BLOOD PRESSURE :_____mmHg	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. 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			

FULL NAME (AS IN PASSPORT) & MATRIC NO.

SECTION 3 - INVESTIGATIONS

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

BLOOD TEST			
ITEM		**DATE TAKEN**	**RESULT**
a.	HEPATITIS Bs ANTIGEN		
b.	HEPATITIS C		
c.	HIV		
d.	VDRL / TPHA		
e.	MALARIAL PARASITE		

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

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

_____

_____

_____

☐ UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

…… ……

Signature of Doctor Date

Name of Doctor : _____

Qualification : _____

Hospital/Clinic : _____

Registration Number : _____

Official stamp :

REMARKS BY UNIVERSITY OFFICIAL: