IHWC-Clinic/V-03/R-01/ED-01062020

الجامعة الإسلامية العالمية ماليزيا
INTERNATIONAL ISLAMIC UNIVERSITY MALAYSIA
Garden of Knowledge and Virtue

GREATER GOMBAK

REGIONAL CENTRE OF EXPERTISE ON EDUCATION FOR SUSTAINABLE DEVELOPMENT
ACKNOWLEDGED BY
UNITED NATIONS UNIVERSITY

HEALTH EXAMINATION REPORT

(for Malaysian students)

STUDENT'S PASSPORT PHOTOGRAPH

GAMBAR PASPORT PELAJAR

(Please complete Part 1 and 2 only. Part 3, 4, 5 is to be filled by the IIUM Medical Officer only)

INSTRUCTION: PLEASE FILL IN CAPITAL LETTERS

ARAHAN: SILA ISI DALAM HURUF BESAR

***PART 1* / BAHAGIAN 1**

ACADEMIC YEAR / TAHUN AKADEMIK

		/		

PROGRAMME / PROGRAM

		/		

SEMESTER

FACULTY / KULLIYYAH

MATRIC NO. / NO. MATRIK

AGE / UMUR

As in the offer letter / Seperti dalam Surat Tawaran

FULL NAME / NAMA PENUH

IDENTITY*CARD* NO. / KAD PENGENALAN

CONTACT *NO.* / NO. TELEFON

NATIONALITY / KEWARGANEGARAAN

DATE OF BIRTH / TARIKH LAHIR

D D M M Y Y Y Y

MALE / LELAKI ☐ *FEMALE* / PEREMPUAN ☐ *SINGLE* / BUJANG ☐ *MARRIED* / KAHWIN ☐

NAME OF GUARDIAN / NAMA PENJAGA

POSTAL ADDRESS OF GUARDIAN / ALAMAT PENJAGA

HOUSE TELEPHONE NO. / NO.TELEFON RUMAH

NO. OFFICE TELEPHONE / NO. TELEFON PEJABAT

NAMA PENUH & NO. MATRIK / FULL NAME & MATRIC NO

PART 2 – Please tick (/) the relevant box / BAHAGIAN 2 – Sila tandakan (/) di kotak berkenaan

Declaration of self and immediate family (Father, mother, siblings) illness. Explain in full if you or your family has any of the following illnesses. / Pengakuan mengenai penyakit yang dihadapi sendiri dan ahli keluarga terdekat (ibu, bapa, adik-beradik). Sila jelaskan dengan lanjut sekiranya anda atau ahli keluarga menghadapi penyakit-penyakit berikut:

MEDICAL PROBLEMS		SELF		IMMEDIATE FAMILY		If "Yes" please state.
		Yes	No	Yes	No	
1	Tuberculosis / Batuk Kering					
2	Hepatitis B					
3	Hepatitis C					
4	HIV / AIDS					
5	Drugs use/abuse / Penggunaan dadah: a. Opiate b. Methamphetamine c. Amphetamine d. Cannabinoids					
6	Congenital or Inherited Disorder / Penyakit Keturunan					
7	Drug Allergy / Alahan Ubat					
8	Mental Illness / Penyakit Mental					
9	Epilepsy / Gila Babi					
10	Stroke/Neurological Disease / Sawan,Strok dan Penyakit Sawan					
11	Diabetis Mellitus / Kencing Manis					
12	Hypertension / Darah Tinggi					
13	Heart or Vascular Disease / Sakit Jantung					
14	Asthma / Lelah					
15	Thyroid Disease / Sakit Tiroid					
16	Kidney Disease / Sakit Buah Pinggang					
17	Cancer / Kanser					
18	History of Surgery / Sejarah Pembedahan					
19	Sexually Transmitted Disease / Sakit Kelamin					
20	History of Blood Transfusion / Sejarah Pemindahan Darah					
21	Hospital Admission for Treatment of COVID-19 Positive / Kemasukan Wad bagi Rawatan COVID-19					
22	Other Illnesses / Lain-Lain Penyakit:					

If you have sought consultation for any of the listed disease/condition, you are required to submit your medical history/report from your treating physician. I hereby certify that the information given above is true. / Jika anda pernah mendapatkan rawatan untuk masalah kesihatan di atas sila kepilkan laporan perubatan atau dokumentasi dari doktor yang merawat anda. Saya dengan ini mengaku segala maklumat kesihatan yang diberi di atas adalah benar.

…… ……..

Date **Name of applicant as indicated in the identification card**

…….. ……..

Applicant's Signature **Applicant's identification card number**

NAMA PENUH &*NO. MATRIK / FULL NAME &MATRIC NO.*

PART 3 – To Be Filled By Examining Doctor / BAHAGIAN 3 – Untuk Diisi Oleh Doktor Yang Memeriksa

Tick as relevant / Tandakan yang berkaitan ☑

1. GENERAL EXAMINATIONS / PEMERIKSAAN UMUM

HEIGHT/TINGGI ☐☐☐ sm/cm WEIGHT/BERAT ☐☐☐ kilogram

PULSE/NADI ☐☐☐ per minute/seminit BP ☐☐☐/☐☐☐ mmHg

a) PALLOR ☐ b) CYNOSIS ☐ c) OEDEMA ☐

d) JAUNDICE ☐ e) LYMPH NODE ☐ f) SKIN ☐

2. EXAMINATION OF EYE / PEMERIKSAAN MATA	RIGHT KANAN	LEFT KIRI	REMARKS/ CATATAN
a. UNAIDED VISION / PENGLIHATAN TANPA KACA MATA	☐	☐	_____
b. AIDED VISION/ PENGLIHATAN TANPA KACA MATA	☐	☐	_____

c. FUNDOSCOPY	NORMAL ABNORMAL	☐ ☐	_____
d. COLOUR VISION/ PENGLIHATAN WARNA	NORMAL ABNORMAL	☐ ☐	_____
3. EXAMINATION OF EAR / PEMERIKSAAN TELINGA	NORMAL ABNORMAL	☐ ☐	_____
4. ORAL CAVITY/ RUANG MULUT	NORMAL ABNORMAL	☐ ☐	_____
5. HEART/ JANTUNG	NORMAL ABNORMAL	☐ ☐	_____
6. a. RESPIRATORY SYSTEM/ SISTEM RESPIRATORI	NORMAL ABNORMAL	☐ ☐	_____

NAMA PENUH & NO. MATRIK / FULL NAME &MATRIC NO.

b.*X-RAY NORMAL ☐ ABNORMAL ☐ _____

- .LAMPIRKAN X-RAY DADA SERTA LAPORAN (filem besar)/
- PLEASE ATTACH CHEST X-RAY AND REPORT (large film)

DATE OF X-RAY TAKEN/ TARIKH X-RAY DIAMBIL

PLACE TAKEN / TEMPAT DIAMBIL

X-RAY REF. NO. / NO. RUJUKAN X-RAY

7. ABDOMEN &HERNIA ORIFICES/ ABDOMEN & RONGGA HERNIA NORMAL ☐ ABNORMAL ☐ _____
8. NERVOUS SYSTEM & MENTAL CONDITION/ SISTEM SARAF & MENTAL NORMAL ☐ ABNORMAL ☐ _____
9. MUSCULOSKELETAL SYSTEM / SISTEM MUSKULOSKELETAL NORMAL ☐ ABNORMAL ☐ _____
10. OTHERS / LAIN-LAIN: _____

PART4 / BAHAGIAN 4

11. EXAMINATION OF URINE / PEMERIKSAAN AIR KENCING

Sugar / Gula _____ *Albumin* _____ *Microscopy* _____

NAMA PENUH & NO. MATRIK / FULL NAME &MATRIC NO.

PART 5 / BAHAGIAN 5

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	General Apprearance		Neat & Tidy		Untidy	
B.	Speech Quality	Coherent	Yes		No	
		Relevant	Yes		No	
C.	Mood	Depressed*	Yes		No	
		Anxious	Yes		No	
		Irritable	Yes		No	
D.	Affect		Appropiate		Inappropiate	
E.	Thought					
	Delusion		Yes		No	
	Suicidality*		Yes		No	
F.	Perception					
	Hallucination		Yes		No	
G.	Orientation					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

NAMA PENUH &NO. MATRIK / FULL NAME &MATRIC NO.

QUESTIONNAIRE (DECLARATION BY STUDENT)

PART A : MOOD		YES	NO
A.	Feeling depressed or low mood most of the day, nearly every day for the past 1 month; may be subjective (e.g. feels sad, empty, hopeless) or observed by others (e.g. appears tearful).		
B.	Markedly reduced interest/pleasure in all (or almost all) activities most of the day, nearly every day; may be subjective or observed by others.		
C.	Difficulty to sleep almost every night.		
If 'Yes' to question 1 or 2, to tick 'Yes' at DEPRESSED in assessement box.			

PART B : SUICIDALITY		YES	NO
A.	Feeling worthless or excessive/inappropriate guilt almost every day.		
B.	Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without specific plan, or suicide attempt, or a specific plan for suicide.		
If 'Yes' to question 3 or , to tick 'Yes' at SUICIDALITY in assessement box.			

PART C : PSYCHOSIS		YES	NO
A.	Seeing image or hearing sounds that occurs (that you feel it is real) in the absence of an actual external stimulus observed by others.		
B.	Continuously believe that somebody is controlling your every move via radio waves or other methods.		
If 'Yes' to question 3 or , to tick 'Yes' at PSYCHOSIS in assessement box.			

PART 6 / BAHAGIAN 6

Certification by Doctor / PENGESAHAN DOKTOR

Please tick (/) in the appropriate box / Sila tandakan (/) di dalam kotak yang berkenaan

*I certify that on this day i have examined /S*aya mengesahkan bahawa hari ini saya telah memeriksa

_____ *I/C /* No. K/P _____

and found that / dan mendapati bahawa *:-*

☐ *The above name is in good health*
Beliau tidak menghadapi apa-apa penyakit dan disahkan sihat

☐ *The above named has* _____
Beliau mengidap

☐ *The above named is undergoing treatment* _____
Beliau sedang mendapatkan rawatan

Signature of Doctor/ Tandatangan Doktor*:* _____ *Date/* Tarikh*:* _____

*Name of Doctor /*Nama Doktor*:* _____

Qualification and Official Stamp of hospital / clinic/Kelulusan dan Cop Rasmi Klinik*:*

_____