

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

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

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

LIST OF CONDITIONS		SELF		IMMEDIATE FAMILY		If "Yes" please elaborate.
		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 / Sawan					
10	Stroke/Neurological Disease /Strok dan Angin Ahmar/Penyakit Saraf					
11	Diabetes Mellitus / Kencing Manis					
12	Hypertension / Darah Tinggi					
13	Heart or Vascular Disease / Penyakit Jantung					
14	Asthma / Lelah					
15	Thyroid Disease / Penyakit Tiroid					
16	Kidney Disease / Penyakit Buah Pinggang					
17	Cancer / Kanser					
18	History of Surgery / Sejarah Pembedahan					
19	Sexually Transmitted Disease / Penyakit Kelamin					
20	History of Blood Transfusion / Sejarah Pemindahan Darah					
21	Hospital Admission for Treatment of COVID-19 / Kemasukan Wad bagi Rawatan COVID-19					
22	Other Illnesses / Lain-Lain Penyakit:					

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

Name of applicant as in IC/ Nama penuh pemohon seperti di dalam kad pengenalan :.....

Applicant's IC No./No. Kad pengenalan pemohon:.....

.....
Date/Tarikh

.....
**Applicant's Signature/
Tandatangan Pemohon**

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

Tick as relevant / Tandakan yang berkaitan

1. GENERAL EXAMINATION / PEMERIKSAAN UMUM

HEIGHT/TINGGI sm/cm

WEIGHT/BERAT kilogram

PULSE/NADI per minute/seminit

BP / mmHg

a) PALLOR

b) CYANOSIS

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 BERKACA 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

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b.*X-RAY

NORMAL

ABNORMAL

- LAMPIRKAN X-RAY DADA SERTA LAPORAN (filem besar)/
- PLEASE ATTACH 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

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- *** Chest X-Ray will be done by IIUM Health & Wellness Centre if there is any indication of (Jika perlu)**

7. ABDOMEN & HERNIAL ORIFICES/
ABDOMEN & RONGGA HERNIA

NORMAL
ABNORMAL

8. NERVOUS SYSTEM & MENTAL
STATUS/
SISTEM SARAF & STATUS MENTAL

NORMAL
ABNORMAL

9. MUSCULOSKELETAL SYSTEM /
SISTEM MUSKULOSKELETAL

NORMAL
ABNORMAL

10. OTHERS / LAIN-LAIN: _____

PART 4 / BAHAGIAN 4

11. EXAMINATION OF URINE / PEMERIKSAAN AIR KENCING

Sugar / Gula _____ Albumin _____ Microscopy _____

12. EXAMINATION OF BLOOD / PEMERIKSAAN DARAH

BLOOD TEST				
	ITEM	POSITIVE/ ABNORMAL	NEGATIVE/ NORMAL	COMMENT
a.	HIV ANTIBODY			
b.	HEPATITIS B ANTIGEN			
c.	VDRL			

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PART 5 / BAHAGIAN 5

MENTAL HEALTH ASSESSMENT BY GENERAL PRACTITIONER

A.	General Appearance		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		Appropriate		Inappropriate	
E.	Thought					
	Delusion		Yes		No	
	Suicidity*		Yes		No	
F.	Perception					
	Hallucination		Yes		No	
G.	Orientation					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

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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.		

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.		

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.		

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 /Saya 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:

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES (STDs) SCREENING
BORANG PERSETUJUAN SARINGAN PENYAKIT KELAMIN

MEDICAL OFFICER/PEGAWAI PERUBATAN

I/Saya, _____

Matric. No./ No. Matrik _____ I/C/ No. Kad Pengenalan _____

hereby agree/*dengan ini bersetuju*

to undergo STDs screening at the IIUM Health and Wellness Centre./*untuk menjalani saringan penyakit kelamin di Pusat Kesihatan & Kesejahteraan UIAM.*

Signature of Student/*Tandatangan Pelajar*

Signature of Witness/*Tandatangan Saksi*

Name of Student/*Nama Pelajar*

Name of Witness/*Nama Saksi*

I/C / No K/P : _____

I/C / No K/P : _____

Date/*Tarikh* : _____

Date/*Tarikh* : _____

AUTHORIZATION FOR ANESTHESIA AND SURGICAL PROCEDURE
(PERAKUAN KEBENARAN BIUS (ANESTHESIA) DAN PEMBEDAHAN

MEDICAL OFFICER/PEGAWAI PERUBATAN

Health & Wellness Centre/*Pusat Kesihatan & Kesejahteraan*
International Islamic University Malaysia/ *Universiti Islam Antarabangsa Malaysia*
Jalan Gombak, 53100 Kuala Lumpur

I _____ NRIC No./Passpot No. _____

Father/ mother/ guardian of (name of the student) _____

hereby authorize the Medical Officer to sign on my behalf for anesthesia or carry out a surgical procedure on the applicant in my absence in the event of an emergency as confirmed by the attending doctor, when required.

Saya _____ *No. K/P* _____

Bapa/ ibu/ penjaga kepada (nama pelajar) _____

dengan ini memberi kuasa kepada tuan menandatangani kebenaran bagi pihak saya, jika pada pandangan doktor yang pelajar ini memerlukan rawatan bius (anesthesia) atau pembedahan, sedangkan saya tidak dapat hadir pada masa yang diperlukan.

I will absolve the International Islamic University Malaysia of any claims or responsibilities from any unfavorable consequences arising from the said procedure.

Saya tidak akan mendakwa atau mengambil sebarang tindakan terhadap Universiti Islam Antarabangsa Malaysia jika berlaku sebarang kemungkinan yang timbul daripada prosedur tersebut.

Name of Father/ Mother/ Guardian
Nama Bapa/ Ibu/ Penjaga

Yours faithfully,
Yang benar,

Signature of Father/Mother/ Guardian
Tandatangan Bapa/Ibu/Penjaga

Address/ *Alamat*

Tel. No./*Nombor telefon*: _____

Date/*Tarikh* : _____