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

RCE GREATER GOMBAK

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

HEALTH EXAMINATION REPORT/ LAPORAN PEMERIKSAAN KESIHATAN FOR MALAYSIAN STUDENT/ UNTUK PELAJAR MALAYSIA

PASSPORT SIZEPHOTOGRAPH (not older than 6months)

GAMBAR SAIZPASPORT (tidak lebih daripada 6 bulan)

INSTRUCTION: PLEASE USE CAPITAL LETTERS

ARAHAN: SILA ISI DALAM HURUF *BESAR* {*SECTIONS 1 & 3(B) to be filled in by the candidate*}/ {SEKSYEN 1 & 3(B) untuk diisi oleh calon}

SECTION 1(A) / SEKSYEN 1(A)

ACADEMIC YEAR / TAHUN AKADEMIK

		/		

PROGRAMME / PROGRAM

		/		

SEMESTER

FACULTY / KULLIYYAH

MATRIC NO. / NO. MATRIK

AGE / UMUR

FULL NAME (as per I. C.) / NAMA PENUH (seperti di dalam kad pengenalan)

IDENTITYCARD NO. / NO. KAD PENGENALAN

MOBILE PHONE NO. / NO. TELEFON BIMBIT

NATIONALITY / KEWARGANEGARAAN

DATE OF BIRTH / TARIKH LAHIR

D	D	M	M	Y	Y	Y	Y

GENDER / JANTINA

MALE / LELAKI ☐

FEMALE / PEREMPUAN ☐

MARRITAL STATUS / STATUS PERKHAWINAN

SINGLE / BUJANG ☐

MARRIED / BERKAHWIN ☐

DIVORCED / BERCERAI ☐

WIDOWED / BALU ☐

NAME OF THE NEXT OF KIN (CLOSEST LIVING RELATIVE) / NAMA SAUDARA TERDEKAT

NEXT OF KIN'S POSTAL ADDRESS / ALAMAT SAUDARA TERDEKAT

RELATION WITH THE NEXT OF KIN/ HUBUNGAN DENGAN SAUDARA TERDEKAT

NEXT OF KIN'S MOBILE PH. NO./ NO. TELEFON BIMBIT SAUDARA TERDEKAT

***FULL NAME (as per I. C.) & MATRIC No. /* NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

SECTION 1(B) – *Please tick (/) the relevant box* / SEKSYEN 1(B) – Sila tandakan (/) di kotak berkenaan

Declaration of health status of self and immediate family (biologic parents & siblings). Explain in full if you have or anyone in the immediate family has any of the following medical problems/ 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 terdekat menghidapi penyakit-penyakit berikut:

	MEDICAL PROBLEMS /CONDITIONS (PENYAKIT)	SELF / SENDIRI		*IMMEDIATE FAMILY /* AHLI KELUARGA TERDEKAT		*IF 'YES' PLEASE EXPLAIN* / SILA JELASKAN JIKA 'YA'
		Yes /*ya*	No / tiada	*Yes* /ya	*No* /tiada	
1	*Tuberculosis*/ batuk kering					
2	*Hepatitis B*					
3	*Hepatitis C*					
4	*HIV / AIDS*					
5	*Drugs use/abuse*/ dadah:					
	Opiate					
	Methamphetamine					
	Amphetamine					
	Cannabinoids					
6	*Congenital/ Inherited disorder(s)*/* penyakit kongenit/ keturunan					
7	*Drug allergy*/ alahan ubat					
8	*Mental Illness(es)/* penyakit mental					
9	*Neurological disorder(s)*/ penyakit Saraf**					
10	*Diabetes mellitus*/ kencing manis					
11	*Hypertension* / darah tinngi					
12	*Heart or Vascular disease(s)*/ penyakit jantung					
13	*Asthma/* lelah					
14	*Thyroid disorder(s)/* (penyakit tiroid					
15	*Kidney disorder(s)*/ penyakit buah pinggang					
16	*Cancer*/ barah					
17	*History of surgery*/ sejarah pembedahan					
18	*Sexually transmitted disease(s)* /penyakit Kelamin					
19	*History of blood transfusion/* sejarah tranfusi darah					
20	*Hospitalization for covid-19 treatment/* kemasukan ke hospital untuk rawatan covid-19					
21	*History of smoking*/ *sejarah merokok*					
22	*Other Illness(es)*/ lain-lain penyakit					
23	***List of current medication(s)***{*(if any*}***/ senarai ubat-ubatan terkini*** *(jika ada)*					

Medical conditions present since birth/* penyakit kongenit/ keturunan. * Neurological disorders include: Migraines, Epilepsy/ Seizures, Stroke, Motor neuron disease, Dementia/ Alzheimer's disease and Parkinson's disease/* (Gangguan neurologi termasuk: Migrain, Epilepsi / Kejang, Strok,Penyakit neuron motorik, penyakit Dementia / Alzheimer dan penyakit parkinson

FULL NAME (as per I. C.) & MATRIC No. / **NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

+

SECTION 1(C)/ SEKSYEN 1(C)

IMMUNIZATION HISTORY (where applicable)		**DATE IMMUNIZED**				
1	Yellow Fever*					
2	BCG					
3	Meningitis (Quadrivalent)					
4	Hepatitis B					
5	Polio					
6	Measles					
7	Rubella					
8	Covid -19 (include vaccine TYPE, e.g. pfizer)					
9	Others: (Please specify)					

*A valid Yellow Fever vaccination certificate is mandatory for all travelers coming from or having transited (more than 12 hours) through countries with risk of Yellow Fever transmission. / Sijil Vaksinasi Demam Kuning yang sah adalah diwajibkan bagi pelancong yang tiba atau transit (lebih dari 12 jam) yang melalui negara-negara dengan risiko penularan Demam Kuning.

The candidate is expected to have taken vaccines listed in the above table (numbers 2-8) **/** Calon diharapkan mengambil vaksin yang tertera di jadual di atas (nombor 2-8).

The candidate is required to bring along the International Certificate of Vaccination for verification of information. / Calon dikehendaki membawa Sijil Vaksinasi Antarabangsa untuk pengesahan maklumat.

If you have sought consultation for any of the listed conditions on page 2, you are required to submit your medical history/report from your attending doctor. Jika anda pernah mendapatkan rawatan untuk sebarang masalah di surat muka 2, sila kemukakan laporan perubatan atau dokumentasi dari doktor yang merawat anda.

I hereby certify that the information given above is true. I also understand that my application/ registration will be rejected/cancelled in case the information given was found untrue/ **Dengan ini saya mengesahkan bahawa maklumat yang diberikan diatas adalah benar. Saya juga memahami bahawa permohonan / pendaftaran saya akan ditolak / dibatalkan sekiranya maklumat yang diberikan didapati tidak benar.**

……………………………………………… ……………………………………………………………………………………

Date/ Tarikh

Name of the candidate as per I. C. / Passport
Nama calon seperti didalam kad pengenalan/Pasport

……………………………………………… …….. ………………………………………………………………………………

Candidate’s I. C. / Passport No.
No. I. C. / Pasport calon

Candidate’s Signature/ Tandatangan calon

FULL NAME (as per I. C.) & MATRIC No. / **NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

SECTION 2 - PHYSICAL EXAMINATION (Sections 2, 3A, 4 & 5 to be completed by the examining doctor)

1. BASIC MEASUREMENTS	
HEIGHT (CM):____________________ WAIST CIRCUMFERENCE (CM):_________	WEIGHT (KG):_______________ BMI (KG/M²):________________
BLOOD PRESSURE (mm Hg): Systolic:______________Diastolic :__________	PULSE RATE : (beats/ min)_________
VISION TEST : Unaided : (R)____ /____ (L)____ /____ Aided : (R)____ /____ (L)____ /____	COLOUR VISION TEST : NORMAL ☐ ABNORMAL ☐
HEARING ABILITY Left : NORMAL ☐ ABNORMAL ☐ Right : NORMAL ☐ ABNORMAL ☐	COMMENT:

2. GENERAL EXAMINATION				
ITEM		PRESENT	ABSENT	COMMENT
A	CYANOSIS			
B	DEFORMITIES			
C	JAUNDICE			
D	NAIL DISORDERS			
E	OEDEMA			
F	PALLOR			
G	SKIN DISEASES			

3. SYSTEMIC EXAMINATION				
ITEM		NORMAL	ABNORMAL	COMMENT
A	ABDOMEN			
B	CARDIOVASCULAR SYSTEM			
C	EARS			
D	EYES {including fundoscopy (if possible)}			
E	HERNIAL ORIFICES			
F	MUSCULOSKELETAL SYSTEM			
G	NECK			
H	NERVOUS SYSTEM			
I	NOSE			
J	ORAL CAVITY / THROAT			
K	RESPIRATORY SYSTEM			

***FULL NAME (as per I. C.) & MATRIC No. /* NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

SECTION 3(A) - MENTAL HEALTH ASSESSMENT

(assessment by the examining doctor)

A	General appearance		Neat &tidy		Untidy	
B	Speechquality	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	
	Suicidality		Yes		No	
F	Perception:					
	Hallucination		Yes		No	
G	Orientation In:					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

FULL NAME (as per I. C.) & MATRIC No. / **NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

SECTION 3(B) - MENTAL HEALTH ASSESSMENT
{QUESTIONNAIRE} (declaration by the candidate)

1. MOOD		YES	NO
A	Feeling depressed or having low mood most of the days, 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 nearly all) activities most of the days, nearly every day, may be subjective or observed by others		
C	Difficulty sleeping almost every night		

2. 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		

3. PSYCHOSIS		YES	NO
A	Seeing images or hearing sounds that occurs (that you feel 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		

FULL NAME (as per I. C.) & MATRIC No. / **NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

SECTION 4 – INVESTIGATIONS

1. URINE TEST				
ITEM		POSITIVE	NEGATIVE	COMMENT
A	ALBUMIN			
B	SUGAR			
C	OPIATES (including codeine,morphine & heroin)			
D	CANNABINOIDS			
E	AMPHETAMINE TYPE STIMULANTS			
F	MICROSCOPIC EXAMINATION			

2. BLOOD TEST				
ITEM		POSITIVE/ ABNORMAL	NEGATIVE/ NORMAL	COMMENT
A	HEPATITIS B ANTIGEN			
B	HEPATITIS C ANTIBODY			
C	HIV ANTIBODY			

FULL NAME (as per I. C.) & MATRIC No. / **NAMA PENUH (seperti di dalam kad pengenalan) & No. MATRIK**

**Chest X-Ray will be done by IHWC if indicated (*X-Ray dada akan dilakukan oleh IHWC jika perlu)

3. CHEST X-RAY:	
CHEST X-RAY FILM NO.	
DATE TAKEN	
PLACE TAKEN	

DOCTOR'S REPORT:

ITEM		NORMAL	ABNORMAL	DETAILS OF ABNORMALITY
A	THORACIC CAGE			
B	HEART SHAPE & SIZE			
C	LUNG FIELDS			
D	MEDIASTINUM & HILAR REGION			
E	PLEURA /HEMIDIAPHRAGMS /COSTOPHRENIC ANGLES			
F	ANY OTHER ABNORMALITIES			
G	OVER ALL IMPRESSION			

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) the appropriate box:

It is certified that I have on this date ______________________________ examined

Mr. / Ms. ______________________________ I. C. / Passport/ No.__________________

and found him / her with the following disease(s)/condition(s) as shown in the below table:

ITEM		YES	NO
1	Tuberculosis		
2	Hepatitis B		
3	Hepatitis C		
4	HIV		
5	Cancer		
6	Epilepsy		
7	Psychiatric Illness		
8	Drugs :		
	Opiates		
	Methamphetamine		
	Amphetamine		
	Cannabinoids		
9	Others (Please specify)		

IT IS HEREBY CERTIFIED THAT:

☐ The above name is in good health

☐ The above name has ______________________________

☐ The above name is undergoing treatment for ______________________________
with list of current medicines ______________________________
____

☐ The above named is unfit to study at IIUM

....
Signature of Doctor

....
Date

Name of Doctor :______________________________

Official stamp :

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

MEDICAL OFFICER / *PEGAWAI PERUBATAN,*

I____

Matric No. ________________________ I. C. / Passport No.______________________________________

hereby agree to undergo STDs/ drugs screening at the IIUM Health and Wellness Centre.

I fully understand the implications involved with the above-mentioned procedure.

*Saya*____

*No. Matrik*_____________________*No. Kad Pengenalan/ No. Pasport*_____________________*dengan ini bersetuju untuk menjalani saringan penyakit kelamin/ dadah di Pusat Kesihatan & Kesejahteraan UIAM. Saya memahami sepenuhnya implikasi yang terlibat dengan prosedur di atas.*

Signature of the candidate/*Tandatangan Calon*

____

Name of the candidate /*Nama Calon*

____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

____

Date / *Tarikh*:____________________________

Signature of the witness/*Tandatangan Saksi*

____

Name of the witness/*Nama Saksi*

____

I. C. / Passport No.:
No. Kad Pengenalan / No. Pasport:

____

Date / *Tarikh:*____________________________