PASSPORT SIZE PHOTOGRAPH (not older than 6 months)

GAMBAR SAIZ PASSPOT (tidak lebih daripada 6 bulan)

HEALTH EXAMINATION REPORT (MALAYSIAN STUDENT)
LAPORAN PEMERIKSAAN KESIHATAN (PELAJAR MALAYSIA)

INSTRUCTION: PLEASE READ CAREFULLY & FILL IN THE FORM IN CAPITAL LETTERS
ARAHAN: SILA BACA DENGAN TELITI & ISI BORANG MENGUNAKAN 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)*

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

ACADEMIC YEAR /*TAHUN AKADEMIK*

2	0			/	2	0		

MATRIC NO. / *NO. MATRIK*

SEMESTER

IDENTITY CARD NO. / *NO. KAD PENGENALAN*

						-			-				

MOBILE PHONE NO. / NO. TELEFON BIMBIT

GENDER/JANTINA

Male/Lelaki ☐

Female/Perempuan ☐

MARITAL STATUS/STATUS PERKAHWINAN

Single/Bujang ☐ Divorced/Bercerai ☐

Married/Berkahwin ☐ Widowed/Balu ☐

ADDRESS/ALAMAT:

PERMANENT / *TETAP*	MAHALLAH ADDRESS/ALAMAT MAHALLAH

EMAIL: ______________________________

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

RELATION WITH THE NEXT OF KIN/*HUBUNGAN DENGAN SAUDARA*

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

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:*

	LIST OF MEDICAL PROBLEMS /CONDITIONS *(SENARAI 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/ B*atuk 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/ A*lahan ubat*					
8	Mental Illness(es*)/ Penyakit mental*					
9	Neurological disorder(s*)/Penyakit Saraf***					
10	Diabetes mellitus/ K*encing Manis*					
11	Hypertension / D*arahTinggi*					
12	Heart or vascular disease(s)/ P*enyakit jantung*					
13	Bronchial asthma*/ Lelah*					
14	Thyroid disorder(s)/ Penyakit Tiroid					
15	Kidney disorder(s*)/* P*enyakit buah pinggang*					
16	Cancer/ B*arah*					
17	History of surgery/ S*ejarah 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)/ L*ain-lain penyakit*					
23	List of current medication(s) {(if any)/ S*enarai 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, Sawan / Kejang, Strok,Penyakit motor neuron, penyakit dementia / Alzheimer dan penyakit parkinson*

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

SECTION 1 (C)/ **SEKSYEN 1 (C)**

IMMUNIZATION HISTORY/SEJARAH IMUNISASI (where applicable)		DATE IMMUNIZED /TARIKH IMUNISASI				
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 travellers 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) 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 report from your attending doctor. */ Jika anda pernah mendapatkan rawatan untuk sebarang masalah di surat muka 2, sila kemukakan laporan perubatan 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. /*Nama calon seperti di dalam kad pengenalan*

____

Candidate's I.C. No./No Kad Pengenalan Calon

____

Candidate's signature/ *Tandatangan Calon*

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

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
1	Cyanosis			
2	Deformities			
3	Jaundice			
4	Nail Disorders			
5	Oedema			
6	Pallor			
7	Skin Diseases			

3. SYSTEMIC EXAMINATION

	ITEM	NORMAL	ABNORMAL	COMMENT
1	Abdomen			
2	Cardiovascular System			
3	Ears			
4	EYES{Including Fundoscopy (If Possible)}			
5	Hernial Orifices			
6	Musculoskeletal System			
7	Neck			
8	Nervous System			
9	Nose			
10	Oral Cavity / Throat			
11	Respiratory System			

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	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	
	Suicidality		Yes		No	
f	Perception:					
	Hallucination		Yes		No	
g	Orientation In:					
	Time		Yes		No	
	Place		Yes		No	
	Person		Yes		No	

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

SECTION 3 (B) - MENTAL HEALTH ASSESSMENT (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		

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			
d	VDRL/ TPHA*			

* TPHA will be done only if VDRL test found positive

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

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			

Please note: CHEST X-RAY IS NOT MANDATORY FOR MALAYSIAN STUDENTS *(Harap maklum: X-Ray dada tiada wajib untuk pelajar pelajar Malaysia)*

*To be done by the ISC if indicated at additional cost *(X-Ray dada akan dilakukan oleh ISC jika perlu dengan kos tambahan*)

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

SECTION 5 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) the appropriate box:

I certify to 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:

ITEMS		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 the Doctor **Date**

Name of the Doctor: ____

Official Stamp:

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

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

I, ____

Matric No.__________________________ I.C. No.____

hereby agree to undergo STDs/ drugs screening at the IIUM Sejahtera Clinic. I fully understand the implications involved with the above-mentioned procedure.

Saya, ____

*No. Matrik*__________________________ *No. Kad Pengenalan* __________________________________

Dengan ini bersetuju untuk menjalani saringan penyakit kelamin/dadah di IIUM Sejahtera Clinic. Saya memahami sepenuhnya implikasi yang terlibat dengan prosedur di atas.

____
Signature of the candidate/*Tandatangan calon*

____
Name of the candidate/*Nama calon*

____
I.C. No. of the candidate / *No. Kad Pengenalan calon*

____
Date/Tarikh

____
Signature of the witness /*Tandatangan saksi*

____
Name of the witness /*Nama saksi*

____
I.C. No. of the witness / *No. Kad Pengenalan saksi*

____
Date/Tarikh