IMPORTANT INFORMATION/ INSTRUCTIONS FOR FILLING IN MEDICAL CHECKUP FORM

This page is a guide only to help you fill in the form. Kindly ignore **it when printing.**
MCU FORM must be printed on both sides to reduce paper burden

Background

Medical checkup (MCU) is compulsory for all newly appointed staff and before renewal of contract It must be done only at the IIUM Clinics (IIUM Sejahtera Clinic Gombak/ Gambang, IIUM Poliklinik Primer Sejahtera Pagoh) and for Kuantan based staff at the Family Health Clinic Kuantan

MCU done at any other place will not be accepted unless (in exceptional cases) prior written permission was obtained from the Chief Medical Officer (CMO)

There are 5 sections & 1 annexure:

Section 1 A: *Personal Particulars* ***(page No. 1)***
Section 1 B: *Health Related Questionnaire* ***(page No. 2)***
Section 1 C*: Immunization History* ***(page No. 3)***
Section 2: Physical Examination **(page Nos. 4 & 5**)
Section 3 A: Mental Health Assessment (**page No. 6**)
Section 3 B: *Mental Health Questionnaire* ***(page No. 7)***
Sections 4 A & 4 B: Investigations (**Page Nos. 8 & 9**)
Section 5: Dental Health Examination (**page No. 10**)
Annexure 1: *Consent Form for Sexually Transmitted Diseases (STDs)* ***(page No. 12)***

Kindly fill in only *Sections 1, 3 B,* & *annexure 1 (page Nos. 1, 2, 3, 7 & 12)*

You are required to:

1. Download and print the Medical Checkup Form (page No. 1 to page No. 12) from the link provided by the Management and Services Division (MSD) through email if you have not received the hardcopy by surface mail yet

2. Fill in all relevant pages (page No. 1 **in CAPITAL LETTERS**) and bring along during MCU

3. Affix a color passport size photograph (not older than 6 months) in the box provided (on the right upper corner of **page No. 1**)

4. Write your full name (**in CAPITAL LETTERS)** & staff number OR I. C (Identity Card)/ Passport number if no staff number assigned yet, legibly in the bar provided on top of each page

5. Bring all the records of current and past medical/ surgical treatment from the health care providers visited including care from alternative medical practitioners and also medicines (including herbal medicines & supplements) currently being taken to clinic during MCU

For appointment/ any other enquiries, kindly call 03-6421 4444/ 03-6421 3273 or walk in

IIUM Sejahtera Clinic

PASSPORT SIZE PHOTOGRAPH

(Not older than 6 months)

HEALTH EXAMINATION REPORT
(New Appointment/Renewal of Contract/Health Screening)

SECTION 1 A – Personal particulars

POSITION OFFERED

FULL NAME (as per I. C./ Passport)

I. C. NO./ PASSPORT NO.

MOBILE PHONE NUMBER

NATIONALITY

RELIGION

RACE

DATE OF BIRTH

AGE

GENDER

MALE ☐

FEMALE ☐

MARITAL STATUS

SINGLE ☐

MARRIED ☐

STAFF NO

KULLIYYAH/ CENTER/ DEPARTMENT/ INSTITUTE/ OFFICE

E-MAIL ADDRESS

ADDRESS

PERMANENT	LOCAL

NEXT OF KIN'S NAME

RELATION WITH THE NEXT OF KIN

NEXT OF KIN'S MOBILE PHONE NUMBER

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 1 B –HEALTH RELATED QUESTIONNAIRE

Declaration of Medical Conditions of self & immediate family (parents, siblings & children). *Explain in full if you have or any one in your immediate family has any of the following conditions.* Please tick (√) in the relevant box

MEDICAL CONDITIONS		SELF		IMMEDIATE FAMILY		IF "YES"PLEASE STATE
		Yes	No	Yes	No	
1	Tuberculosis					
2	Hepatitis B					
3	Hepatitis C					
4	HIV/AIDS					
5	Drug addiction (cannabinoids, opiates, methamphetamine, amphetamine)					
6	Alcohol addiction					
7	History of smoking/ vaping (current and past)					
8	Congenital/Inherited disorder					
9	Drug allergy					
10	Mental health illness					
11	Epilepsy					
12	Migraine					
13	Diabetes mellitus					
14	Hypertension					
15	Heart/ vascular disease					
16	Bronchial asthma					
17	Thyroid disorder					
18	Kidney disorder					
19	Cancer					
20	History of surgery					
21	History of stroke					
22	Prolong fever & night sweats					
23	Sexually transmitted disease					
24	Menstrual problems					
25	Breast lump					
26	Testicular lump					
27	Alternative treatment for any mental health problem					
28	Any serious injury					
29	Any serious head injury					
30	Physical disability					
31	Piles (Hemorrhoids)					
32	Recurrent painful & swollen joints					
33	Easy bleeding (bruises)					
34	Chest pain on physical exertion					
35	Easy fatigability					
36	Hearing problem					
37	Vision problem					
38	Recent change in appetite/ weight					

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 1 B – HEALTH RELATED QUESTIONNAIRE

MEDICAL CONDITIONS		SELF		IMMEDIATE FAMILY		IF "YES" PLEASE STATE
		Yes	No	Yes	No	
39	Currently pregnant (Female candidate)					
40	Any treatment from a registered medicalpractitioner for any illness or injury					
41	Weak urine stream (males only)					
42	Passing urine more than once at night					
43	Recurrent stomach pain					
44	Chronic constipations or diarrhea					
45	History of blood transfusion					
46	History of hospitalization					
47	Any other illness not in the list					
48	List of current medicines being taken (including supplements & herbal medicines)					

SECTION 1 C - IMMUNIZATION HISTORY

NAME OF VACCINES		DATE IMMUNIZED
1	Yellow Fever	
2	BCG	
3	Meningitis (Quadrivalent)	
4	Hepatitis B	
5	Polio	
6	Measles	
7	Rubella	
8	COVID -19 Vaccine (Pfizer, Astrazeneca & Sinovac etc.)	
9	Others: (specify)	

Notes:

1. * A valid Yellow Fever vaccination certificate is required from all travelers coming from or having transited more than 12 hours through countries with risk of Yellow Fever transmission
2. The candidate is required to bring along the International Certificate of Vaccination for verification

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I hereby confirm that the information given at page Nos. 2 & 3 is true. I understand well that the IIUM has a right to revoke my appointment in case any of the information given proves untrue or withheld. I hereby undertake that the IIUM will not be held legally responsible for revocation if any

I also authorize IIUM Sejahtera Clinic to share this information with any of the IIUM authority/ department concerned

______________________________ ______________________________

Date **Candidate's signature**

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 2 - PHYSICAL EXAMINATION

1. BASIC MEASUREMENTS

WEIGHT:____________kg	BLOOD PRESSURE :________________mm Hg
HEIGHT: ____________m	PULSE RATE:___________beats/ min
BMI :____________kg/m2	

GENERAL CONDITION

2. EYE

(i) Vision

Right Eye		Left Eye	
Without Glasses		Without Glasses	
With Glasses		With Glasses	

(ii) Color Vision ☐ Normal ☐ Abnormal

(iii) Squint ☐ Present ☐ Absent

3. EAR / HEARING

(i) Physical Examination			
	Normal	Abnormal	Remarks
Right ear			
Left ear			
(ii) Hearing			
	Normal	Abnormal	Remarks
Right ear			
Left ear			

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 2 – PHYSICAL EXAMINATION

4. THROAT CAVITY

Please refer to Section 5 (Page 10)

Normal	Abnormal	Remarks

5. RESPIRATORY SYSTEM

Normal	Abnormal	Remarks

6. CARDIOVASCULAR SYSTEM

(ECG is compulsory for all new staff. For ROC & Health screening above age 40 years (if indicated). ECG tracing must be signed, dated by the examining doctor & attached with this FORM)

Normal	Abnormal	Remarks

7. ABDOMEN

Normal	Abnormal	Remarks

8. UROGENITAL SYSTEM

Normal	Abnormal	Remarks

9. NEUROLOGICAL SYSTEM

Normal	Abnormal	Remarks

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 3 A - MENTAL HEALTH ASSESSMENT

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	

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 3 B - MENTAL HEALTH QUESTIONNAIRE

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 images or hearing sounds thatoccurs (that you feel it is real) in the absence of an actual external stimulusobserved by others		
B	Continuously believe that somebody is controlling your every move via radio waves or other methods		

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 4 A - INVESTIGATIONS

1. URINE TEST				
ITEM		**POSITIVE**	**NEGATIVE**	**COMMENT**
a	Albumin			
b	Sugar			
c	Microscopic Examination			

BLOOD TEST				
ITEM		**POSITIVE/ ABNORMAL**	**NEGATIVE/ NORMAL**	**COMMENT**
A	HEPATITIS B ANTIGEN			
B	HEPATITIS C ANTIBODY			
C	HIV ANTIBODY			
D	MALARIA PARASITES*			
E	VDRL / TPHA**			
F	FULL BLOOD COUNT			
G	FASTING BLOOD SUGAR			
H	HBA1C			
I	RENAL PROFILE			
J	LIVER FUNCTION TEST			
K	SERUM URIC ACID			
L	LIPID PROFILE			
M	THYROID FUNCTION TEST			

*Not compulsory for Malaysians

**TPHA will be done only if VRDL was found reactive

Full details of blood test results are COMPULSORY and must be attached with this form

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 4 B - INVESTIGATIONS

CHEST X-RAY

CHEST X-RAY INFORMATION	
CHEST X-RAY 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	FOCAL LESION			
G.	ANY OTHER ABNORMALITIES			
H.	OVER ALL IMPRESSION			

Important: CXR is **COMPULSORY** for all new staff. *For ROC & Health screening above age 40 years (if indicated)*

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

SECTION 5 – DENTAL HEALTH EXAMINATION

(Dental checkup is compulsory for all new staff. For ROC & health screening above age 40 years)

IT IS HEREBY CERTIFIED THAT:

Mr./ Ms. ____

I.C. No./Passport No.________________________________has undergone a dental

examination on:______________________from______________until______________

and was found having:

☐ Good dental health

☐ Has a dental problem:

☐ Infection ☐ Caries ☐ Other:

☐ Periodontal Disease ☐ Tooth Loss ______________________

____

Signature : ____

Name of Dentist : ____

Designation : ____

Hospital/Clinic : ____

Registration Number : ____

Date : ____

Official stamp :

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

CERTIFICATION BY THE EXAMINING DOCTOR

IT IS HEREBY CERTIFIED THAT:

☐ The above named is in good health & fit to work

☐ The above named has unsatisfactory outcome of the Medical Checkup

☐ The above named has the following medical condition(s):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

☐ The above named is on the following medication(s):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

…………………………………………….. ……………………………

Signature of the Doctor Date

Name of the Doctor : ______________________________

Official stamp :

MCU verification by the ISC Medical Officer (If Medical Check Up done at any place other than (ISC/ FHC)

☐ Fit to work

☐ Unsatisfactory outcome of the Medical Checkup

……………………………………………… …………………………………

Signature of the Doctor Date

Name of the Doctor : ______________________________

Official stamp :

ANNEXXURE 1

FULL NAME & STAFF NUMBER (I. C. OR PASSPORT NO. IF NO STAFF NUMBER ASSIGNED YET)

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES (STDs)

I,____

Staff No.__________________________I.C No./ Passport No. __________________________

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

___________________________ ___________________________

Name of the candidate **Name of the witness**

___________________________ ___________________________

Signature of the candidate **Signature of the witness**

___________________________ ___________________________

I.C No./ Passport No. of the candidate **I.C No./ Passport No. of the witness**

____

Date