**UNIVERSITI MALAYSIA TERENGGANU**

**HEALTH EXAMINATION REPORT FOR INTERNATIONAL STUDENT**

**AND ACCOMPANYING PERSON**

Passport size photo

**PLEASE USE CAPITAL LETTERS**

**SECTION 1** (To be completed by candidate)

**(PART A)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **FULL NAME (AS IN PASSPORT)** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **INTERNATIONAL PASSPORT NO.** | | | | | | | | | | | | | | | | | | | |  |
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| **NATIONALITY** | | | | | | | | | | | | | | | | | | **CONTACT NUMBER** | | | | | | | | | |
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| **DATE OF BIRTH** **AGE** **SEX**  **MARITAL STATUS** | | | | | | | | | | | | | | | | | | | | | | | | | |
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| D | D | M | M | Y | Y |  |  |  |  |  |  |  |  | FEMALE |  |  |  |  |  |  |  | MARRIED |  |  |  |

**ACADEMIC YEAR STUDENT ID**

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| **PROGRAMME OF STUDY** | | | | | | | | | | | | | | | | | | |  | | **PROGRAMME CODE** | | | | | |
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| **NEXT OF KIN’S ADDRESS** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **NEXT OF KIN’S CONTACT NUMBER** | | | | | | | | | | | | | | . | | | | | | | | | | | | | |
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**SECTION 1**

**(PART B)** *–* Please tick ( √ ) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses. \* Immediate family refers to father, mother, brothers / sisters

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| **MEDICAL PROBLEMS** | **SELF** | | **IMMEDIATE FAMILY** | | **If “Yes” please state.** |
| **Yes** | **No** | **Yes** | **No** |
| 1. Congenital or inherited disorder |  |  |  |  |  |
| 1. Allergy |  |  |  |  |  |
| 1. Mental illness |  |  |  |  |  |
| 1. Fits, stroke, other   neurological disease |  |  |  |  |  |
| 1. Diabetes Mellitus |  |  |  |  |  |
| 1. Hypertension |  |  |  |  |  |
| 1. Heart or vascular disease |  |  |  |  |  |
| 1. Asthma |  |  |  |  |  |
| 1. Thyroid disease |  |  |  |  |  |
| 1. Kidney disease |  |  |  |  |  |
| 1. Cancer |  |  |  |  |  |
| 1. Tuberculosis |  |  |  |  |  |
| 1. Drug addiction |  |  |  |  |  |
| 1. AIDS, HIV |  |  |  |  |  |
| 1. History of surgery |  |  |  |  |  |
| 1. Other illnesses |  |  |  |  |  |

Current medication (Long term) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **IMMUNIZATION HISTORY**  **(where applicable)** | **DATE IMMUNIZED** | | | | |
| 1. Yellow Fever |  |  |  |  |  |
| 1. BCG |  |  |  |  |  |
| 1. Meningitis (Quadrivalent) |  |  |  |  |  |
| 1. Hepatitis B |  |  |  |  |  |
| 1. Others: |  |  |  |  |  |

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

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|  |  |  |
| Date |  | Signature of candidate |

## **SECTION 2 - PHYSICAL EXAMINATION**

To be filled by examining doctor

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| **1. BASIC MEASUREMENT** | |
| HEIGHT : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ m | BLOOD PRESSURE : \_\_\_\_\_\_\_\_\_\_\_\_\_ mmHg |
| WEIGHT : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ kg | PULSE RATE : \_\_\_\_\_\_\_\_\_\_\_\_\_ / min |
| VISION TEST : Unaided : (R) \_\_\_\_\_\_\_ (L) \_\_\_\_\_\_\_\_  Aided : (R) \_\_\_\_\_\_\_ (L) \_\_\_\_\_\_\_\_ | COLOUR VISION TEST :  NORMAL / ABNORMAL |

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| **2. GENERAL EXAMINATION** | | | |
| **ITEM** | **YES** | **NO** | **COMMENT** |
| 1. DEFORMITIES |  |  |  |
| 1. PALLOR |  |  |  |
| 1. CYANOSIS |  |  |  |
| 1. JAUNDICE |  |  |  |
| 1. OEDEMA |  |  |  |
| 1. SKIN DISEASES |  |  |  |

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| **3. SYSTEMIC EXAMINATION** | | | |
| **ITEM** | **NORMAL** | **ABNORMAL** | **COMMENT** |
| 1. EYES (including funduscopy) |  |  |  |
| 1. EARS |  |  |  |
| 1. NOSE |  |  |  |
| 1. ORAL CAVITY / THROAT |  |  |  |
| 1. NECK |  |  |  |
| 1. HEART |  |  |  |
| 1. LUNGS |  |  |  |
| 1. ABDOMEN / HERNIA ORIFICES |  |  |  |
| 1. NERVOUS SYSTEM |  |  |  |
| 1. MENTAL CONDITION |  |  |  |
| 1. MUSCULOSKELETAL SYSTEM |  |  |  |

## **SECTION 3 - INVESTIGATIONS**

|  |  |  |
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| **URINE TEST** | | |
| **ITEM** | **DATE TAKEN** | **RESULT** |
| 1. ALBUMIN |  |  |
| 1. SUGAR |  |  |
| 1. MICROSCOPIC |  |  |
| 1. MORPHINE |  |  |
| 1. CANNABIS |  |  |
| 1. AMPHETAMINES TYPE STIMULANT |  |  |

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| **BLOOD TEST** | | |
| **ITEM** | **DATE TAKEN** | **RESULT** |
| 1. HEPATITIS Bs ANTIGEN |  |  |
| 1. HEPATITIS C |  |  |
| 1. HIV |  |  |
| 1. VDRL / TPHA |  |  |
| 1. MALARIAL PARASITE |  |  |

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| **CHEST X-RAY INFORMATION** | |
| CHEST X-RAY NO. |  |
| DATE TAKEN |  |
| PLACE TAKEN |  |
| REPORT |  |
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## **SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR**

Please tick (√) in the appropriate box

I certify that I have on this date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ examined

Mr / Ms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Passport No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and found him / her :-

|  |
| --- |
| IN GOOD HEALTH |

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| HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| UNDERGOING TREATMENT FOR: (Please State)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Date |  |  | Signature of Doctor | : |  |
|  |  |  | Name of Doctor | : |  |
|  |  |  | Qualification | : |  |
|  |  |  | Hospital / Clinic Registration Number | : |  |

Official stamp :

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Remarks By University/College Official :

**NAME OF PANEL CLINICS FOR UMT INTERNATIONAL STUDENTS**

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| **New Students** | **Current Students** |
| **Klinik Perubatan Chong**  37 Jalan Tok Lam  20100 K. Terengganu  Tel : 09-6235626 | **Klinik Perubatan Chong**  37 Jalan Tok Lam  20100 K. Terengganu  Tel : 09-6235626 |
| **Klinik Rahim Hamzah Halim & Razali Sdn Bhd**  No 364, Jln Sultan Omar  20300 K. Terengganu  Tel: 09-6223621 | **Klinik Rahim Hamzah Halim & Razali Sdn Bhd**  No 364, Jln Sultan Omar  20300 K. Terengganu  Tel: 09-6223621 |
| **Kuala Terengganu Specialist**  No. 443B Wisma TDM  Jln. Kamaruddin  20400 K. Terengganu  Tel: 09-6245353 | **Klinik Syed Salleh Dan Rakan-Rakan**  **(Dr Azlina Bt Aziz)**  B 74 Kampung Pak Tuyu, Mengabang Telipot  21030 Kuala Terengganu  Tel:09-6699599 |
|  | **Klinik Addeen**  16132 A, Jalan Tengku Ampuan Intan Zahar  Gong Badak, 21300 Kuala Terengganu  <Tel:09-6660544> |
|  | **Klinik Aishah**  61 A Jln Tok Lam  20100 K.Terengganu  <Tel:09-6234510> |