**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** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | MALE |  |  |  |  |  |  |  | SINGLE |  |  |  |
| 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** |
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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  |  |
|  |
|  |

## **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 |

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

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

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

 Official stamp :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Remarks By University/College Official :

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

|  |  |
| --- | --- |
| **New Students** | **Current Students** |
| **Klinik Perubatan Chong** 37 Jalan Tok Lam20100 K. TerengganuTel : 09-6235626 | **Klinik Perubatan Chong** 37 Jalan Tok Lam20100 K. TerengganuTel : 09-6235626 |
| **Klinik Rahim Hamzah Halim & Razali Sdn Bhd**No 364, Jln Sultan Omar20300 K. TerengganuTel: 09-6223621 | **Klinik Rahim Hamzah Halim & Razali Sdn Bhd**No 364, Jln Sultan Omar20300 K. TerengganuTel: 09-6223621 |
| **Kuala Terengganu Specialist**No. 443B Wisma TDMJln. Kamaruddin20400 K. TerengganuTel: 09-6245353 | **Klinik Syed Salleh Dan Rakan-Rakan****(Dr Azlina Bt Aziz)**B 74 Kampung Pak Tuyu, Mengabang Telipot21030 Kuala TerengganuTel:09-6699599 |
|  | **Klinik Addeen**16132 A, Jalan Tengku Ampuan Intan ZaharGong Badak, 21300 Kuala TerengganuTel:09-6660544 |
|  | **Klinik Aishah**61 A Jln Tok Lam20100 K.TerengganuTel:09-6234510 |