**KINGS AND QUEENS MEDICAL UNIVERSITY COLLEGE, GHANA**

# PHYSICAL EXAMINATION FORM FOR STUDENTS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | Sex  | □ Male□ Female | Birth Day-Month-Year / / 20....... | Photo(stampedOfficial Stamp) |
| Present mailing address |  | BloodType |
| Nationality |  | Birth Place |  |
| Have you ever had any of the following diseases?(Each item must be answered “yes” or “No” Typhus fever…. □No □Yes Bacillary dysentery ……………. □No □Yes Poliomyelitis ….. □No □Yes Brucellosis ………………. □No □Yes Diphtheria …… □No □Yes Viral hepatitis ………....... □No □Yes Scarlet fever….. □No □Yes Puerperal streptococcus infection …….. □No □Yes Relapsing fever… □No □Yes  Typhoid and paratyphoid fever ……… ……. □No □Yes Epidemic cerebrospinal meningitis ………… □No □Yes |
| Do you have any of the following diseases or disorders endangering the public order and security?(Each item must be answered “Yes” or “No”) Toxicomania…………………………………………………………□No □Yes Mental confusion…………………………………………… □No □Yes Psychosis: Manic psychosis……………………………………… □No □Yes Paranoid psychosis……………………………………………… □No □Yes Hallucinatory psychosis…………………………………………… □No □Yes |
|  Height …………….cm |  Weight ………….kg |  Blood pressure ………mmHg |
| Development | Nourishment…… | Neck……….. |
|  L….. Vision R….. |  L .… Corrected Vision R….. | Eyes…….. |
| Colour Sense……….. | Skin…….. | Lymph Nodes… |
| Ears ….. | Nose….. | Tonsils… |
| Heart….. | Lungs….. | Abdomen….. |
| Spine |  | Extremities |  | Nervous system |  |
| Other abnormal findings |  |
| Chest X-rayExam(Attachedchest X-rayreport |  | ECG |  |
| Laboratory exam(Attached test report of HIV/ AIDS, Syphilis, Hepatitis etc) |  Sickling Test…………………Hb ………………………….. HIV 1 (ELISA) ……………….HIV 2 (ELISA) ……………… Syphilis Serology / (VDRL) ……Sputum for AFB ………………..Hepatitis Test ( HBsAg): ………Urine Routine Examination: …….. |
| **None of the following diseases or disorders were found during the present examination** Cholera …... □No □Yes Venereal Disease…………..□No □Yes Yellow fever … □No □Yes Lung Tuberculosis…….........□No □Yes Hepatitis…….. □No □Yes AIDS …………………….□No □YesLeprosy ……… □No □Yes Psychosis…………………□No □Yes |
|  Suggestion of Physician: Official Stamp of Doctor / Hospital Name of Physician:  Signature of physician: ………………….. Date:  |