OBAFEMI AWOLOWO UNIVERSITY, NIGERIA.

The Postgraduate College

OAU FORM ADM. 'E'

- **To be completed in Duplicate**

From: Secretary
Postgraduate College

To: Director, Medical & Health Services

Health Centre

Photograph

Please note that Candidate Reg. No……

Mr./Mrs./Miss……
Surname **Other Names**

whose photograph appears above has been found qualified for admission into…….

Faculty of……..……and can now be registered in the Health Centre.

……. **……..……**
Date **for Secretary**

OBAFEMI AWOLOWO UNIVERSITY
ILE-IFE, NIGERIA.

This questionnaire is designed to gather information about your past and current health. Please read all directions carefully, and answer every question as accurately as you can. This information will be held in strictest confidence and will be used only for medical purposes by your Health Service. It will also enable the Health Centre to find out how best to help you whilst you remain a member of the University.

IDENTIFICATION:

NAME:.....
SURNAME **OTHER NAMES**

LOCAL ADDRESS:……
ROAD **HALL OR** **STREET NAME**

Room No. If in Hall……

HOME ADDRESS: STREET…… **CITY:**…….

TELEPHONE:…… **STATE:**……

SEX: MALE…… **FEMALE**……**HEIGHT**……**WEIGHT**……..

TODAY'S DATE…… …… …… **BIRTH DATE:** …… …… ……
DAY **MTH** **YR** **DAY** **MTH** **YR**

CLASS: STUDENT: **UNDERGRADUATE:**……..**GRADUATE**……..
STAFF: **JUNIOR**…… **SENIOR:**……..

NEXT OF KIN: **PARENT/GUARDIAN**

NAME: ……..
SURNAME **OTHER NAMES**

ADDRESS: **STREET**…… **CITY**……

TELEPHONE:…….. **STATE:**……..

RELATIONSHIP……..

DEMOGRAPHIC:

Where were you born?	**Nigeria**……..……	**Others:**……..…….
Citizenship:	**Nigeria**……..	**Others:**……..…….
Family: Position:	**1 2 3 4 5 6 7 8 9 10**	**Children**…….
	Mother: Alive……..……..	**Dead**……..…….
	Father: Alive……	**Dead**……..

Marital Status: Single……**Married**……**divorced**……**Separated**……
Widowed……. **No of Children:**……..

Means of Support: Self……**Family**…… **Other**…….. **Govt**……

Religious Preference:…….

In what type of area did you spend most of your childhood?
Village……**Small Town**……**City or Urban**…….

What income level was your family generally in during your childhood?
Salaried……**Self employed**…….**(Range of Income)**

Farm……. **(small/large)**

ALLERGIES

An allergy is a skin rash, hives, joint pair swollen glands, stuffy nose and or fever after exposure to something to which you are allergic.

Yes No
Do you have any ALLERGIES?
If "Yes" check those items to which you are allergic
Aspirin……..

Certain foods
Dust……
Feathers…….....
Novacain……
Penicillin……..
Chloroquine ……
Camoquine……..
Sulfa…….
Item not listed……

IMMUNIZATIONS:

Check whether or not you have had each immunization listed, and enter the year you received the last immunization.

Yes	No	Immunization	Year last received
……	……	DPT	……
……	……	Cholera	…….
……	……	German Measles (Rubella)	..……
……	……	Measles	……..
……	……	Mumps	…….
……	……	Polio-oral	…….
……	……	Polio-shots	……
……	……	smallpox	…..……
……	……	tetanus toxoid	..…
……	……	Tuberculosis BCG	…..
……	……	TAB (Typhoid Fever)	….
……	……	Whooping cough	
……	……	Yellow fever	……

ILLNESSES

Check whether or not YOU or YOUR BLOOD RELATIVES have or have had the illnesses listed.

Your blood relatives include your sisters, brother, children, parents, and grandparents

You			Relative		
Yes	No	Disease	Yes	No	
……	……	Alcoholism	……	……	
.....	.....	Allergies	……	……	
……	……	Anaemia	……	……	
……	……	Asthma	……	……	
……	……	Bleeding trait	……	……	
……	……	Cancer	……	……	
……	……	recurrent Diarrhoea	……	……	
……	……	Sickle Cell	……	……	
……	……	Deafness (Before 50)	……	……	
……	……	Depression	……	……	
……	……	Diabetes (Sugar)	……	……	
……	……	Chronic Cough	……	……	
……	……	Epilepsy	……	……	
……	……	Eye problem	……	……	
……	……	Goiter	……	……	
……	……	Heart disease	……	……	
……	……	High blood pressure	……	……	
……	……	Fainting spells	……	……	
……	……	Hypoglycemia (low blood sugar)	……	……	
……	……	Insanity	……	……	
……	……	Kidney disease	……	……	
……	……	Mental retardation	……	……	
……	……	Migraine headaches	……	……	
……	……	Nervous breakdown	……	……	
……	……	Obesity (more than 20 Ibs Overweight)	……	……	

HOSPITALIZATION

Yes No

Have you ever been ADMITTED to a Hospital?
(Stayed in a Hospital? As a PATIENT)
If "you" enter total number of times for each reason, and then indicate if ANY of these admission occurred within past year.

No Times	Reason	Past Year Yes	Past Year No
……	Check up (Medical Test)…..	……	….
…… ….	Illness…..	……	….
…… ….	Injury (Accidents)….	……	….
…… ….	Mental Illness……	……	….
…… ….	Operation….	……	….
…… ….	Pregnancy	……	….

…… ….	Peptic ulcer	……	….
…… ….	Stroke	……	….
…… ….	Suicide	……	….
…… ….	Tuberculosis	……	….

DISABILITY: Do you have –

Yes	No	
…… ….		Permanent disability due to illness?
…… ….		Permanent disability due to injury?
…… ….		Permanent disability from birth?

OTHER MEDICAL PROBLEMS

Whether or not you have or have had the ILLNESSES or INJURIES listed.

Yes	No	Problem	Yes	No	Problem	Yes	No	Problem
……	…	Acne Pimples	……	……	Skin rashes	……	……	Appendicitis
……	….	Arthritis	……	……	Back strain	……	……	Bladder Infection
……	……	Cystitis	……	……	Chronic cough	……	……	Chicken pox
……	……	Eye problems	……	……	Gall bladder	……	……	German measles
……	……	Gonorrhea	……	……	disease	……	……	Hearing problems
……	……	Jaundice	……	……	Haemorrhoids	……	……	Hives (Urticaria)
		(yellow eyes)	……	……	Kidney infection	……	……	Kidney stone
……	……	Knee Injury	……	……	Lung	……	……	disease
……	……	Malaria	……	……	Measles	……	……	Meningitis
……	……	Mumps	……	……	Measles disease	……	……	Neck strain
……	……	Nervous stomach	…..	…..	Osteomyelitis	……	……	Ovarian cyst
……	……	Pelvic infection	……	……	Bone infection	……	……	Vein infection
……	……	Phlebitis	……	……	Pneumonia	……	……	Polio
……	……	Prostate infection	…….		Slipped disc	……	……	Syphilis
……	……	Testicle infection	……	……	Typhoid fever	……	……	Whooping cough

FRACTURES (Broken Bones)

…… …… Have you had any FRACTURES

If "Yes" check below any fractures you have had.

……. Skull
……. Nose
……. Jaw
……. Neck
Left….indicate SITE…..Right
…….Collarbone (Clavicle…….
……Shoulder….
…Arm.(Shoulder to elbow)….
…….Ribs
…….Back
…….Tailbone
…….Pelvis
…… ……Forearm (elbow to wrist)……
…… ……Wrist….
……. Hand (wrist to fingers)……
……. Fingers……
……. Hip……
……. Thigh (hip to knee)……
……. Kneecap……
…… Leg (Knee to ankle)……
…… Ankle……
…… Foot (ankle to toes)…..
…… Toes……

OPERATIONS:

An operation is a surgical procedure usually performed ina n operating room in a hospital.

Yes No

…… Have you had any OPERATION?

If "Yes" check those operations you have had.

…… Appendix	**…… Back**	**……Brain**	**……Bone**	**…… Breast**
…… Colon	**…… Consection (caesarian)**	**……Ctstoscopy (bladder)**	**……Joint**	**…… Kidney**
…… Hysterectomy	**…… Long**	**…… Neck**	**……Nose**	**…… Ovary**
…… Prostate	**……D and C**	**…… Ears**	**……Eyes**	**…… Heart**
…… Ballbladder	**…… Homorrhoids**	**……Hernia**	**……Spleen**	**…… Stomach**
…… Testicle	**……Thyroid**	**…… Tubal litigation**	**……Tonsils**	**……Other, not listed**

MEDICATIONS

…… Do you take any MEDICINE frequently or regularly?

If "Yes" check those medications below

…… Antacid (for ulcer)	**Antidepressant**	**…… Antihistamine**	**…… Aspirin**
…… Asthma medicine	**…… Blood tonic**	**…… Birth control pill**	**…… Cortisonesteroid**
…… Cough medicine	**…… Diabetic pill**	**…… Diet pill**	**……Diuretic (water)**
…… Ear drops	**…… Eye drops**	**…… Headache medicine**	**……Heart medicine**
…… Penicillin	**…… Sleeping pill**	**…… Stomach medicine**	**……Sulfa (M&B)**
…… Thyroid hormone	**……Tranquilizer**	**…… Vitamins**	**……Others not listed**
……High blood pressure medicine	**……Insulin ……for heart**	**…… Iron …… nerve medicine**	**……Laxative (Purgative)**
……Nose drops			

DRUGS Do you generally or frequently-

Yes No

…… …… Smoke marijuana?
…… …… Use amphetamines (proplus Reactivan, lexa)?
…… …… Use depressants (Mandrax barbiturates)?
…… …… Use hallucinogens (LSD)?
…… …… Use narcotic (heroin morphine)?
…… …… know the common names and appearance of the various forms of the above drugs?
…… …… Formerly used drugs but stopped?
…… …… Sleeping tablets (barbiturates, valium, Mogadon)
…… …… Tranquillizers - Librium
…… …… Valium.

TRAUMA, ACCIDENTS AND OTHER HAZARD

Do you frequently

…… …… Ride a bicycle?
…… …… Ride a motorbike or motorcycle?
…… …… Ride a motorcycle without helmet and jacket?
…… …… Tend to exceed the speed limit while driving?
…… …… Drive after drinking alcohol or taking drugs?
…… …… Ask for lifts or give lift to others.
…… …… Get exposed to insecticides or dangerous …… chemicals
…… …… Know how to swim?
…… …… Know how to give first aid.

HABITS AND RISK FACTORS

Your habits influence your ability to achieve and maintain good health and long life. Most of the questions on this page reflect factors which increase your risk of developing physical or emotional problems. Please answer each question realistically.

You are not being "graded", and this is not a test.

EATING Do you generally or frequently.

Yes No

…… …… Eat irregularly, skip meals?
…… …… Eat lots of animal fats?
…… …… Eat lots of dairy products? (milk cheese)
…… …… Eat lots of sugar, cake, starches?
…… …… Drink 5 or more cups of coffee Per day
…… …… Drink 5 or more soft drinks per day.
…… …… Tend to stay overweight?
…… …… Eat regular, well balanced meals even if trying to lose weight.
…… …… Eat lots of fruits?
…… …… Eat lots of vegetable?

EXERCISE Do you generally or frequently-

Yes No

… …… Get heavy exercise on an irregular basis?

…… …… Consider walking strenuous exercise?
…… …… Get some type of regular exercise?
…… …… Get regular strenuous exercise such as running, swimming, bicycling, footballing?

SMOKING

Yes No

…… …… Do you smoke a pipe?
…… …… Do you smoke cigar?
…… …… Do you currently smoke cigarettes?
…… …… Did you formerly smoke cigarettes but stopped completely?

If you have ever smoked cigarettes, specify amount and duration-

…… …… Less than ½ pack/day….. Less than 1 year
…… …… ½ to 1 pack/day …… 1 to 5 years
1 to 2 packs/day …… 5 to 10 years
…… …… over 2 packs/day …… over 10 years

ALCOHOL

Yes No

…… …… Do you drink alcohol?
…… …… Did you formerly drink alcohol but stopped

…… …… If you have ever drunk alcohol, specify amount and duration-

…… …… Occasionally, socially …… Less than 1 yr
…… …… Several drinks/week …… 1 to 5 years
several drinks/day …….5 to 10 years
…… …… more than 3 drinks /day ...….. Over 10 years.

INFORMATION Do you want further information on the following, or help with problems you may encounter in the areas described?

Yes No

…… …… Birth control
…… …… Venereal disease
…… …… Cigarette smoking
…… …… Alcoholism
…… …… Drug abuse
…… …… Emotional problems
…… …… Sexual problems
…… …… Marital problems
…… …… General health hazards
…… …… How to cope with loneliness
…… …… What to do if a medical emergency occurs
…… …… Malaria prevention
…… …… Sickle Cell
…… …… Hypertension

… … Frequent sore throats (more than friends)?
… … Persistent or frequent hoarseness?
… ... Unexpected swelling in front of neck?
… … Frequent toothaches or bad teeth ?

… … Bleeding or sore gums?
… … Persistent sore tongue?
… … Wear upper plate (false teeth)
… … Wear tower (false teeth) ?

REVIEW OF SYSTEMS

Answer every question. The SYMPTOMS asked About concern those may have had IN THE PAST YEAR unless otherwise specified

HEAD DO you have or have had -

Yes No.
… … Staggering or balance problems ?
… … Lightheadedness on standing up ?
… … Lightheadedness unrelated to body position ?
… … Spinning sensation or dizziness ?
… … Fainting spells ?
… … Convulsions or "fist"?
… … Weakness in arm (s)?
… … Weakness in leg (s)?

… … Numbness or tingling in arm (s) ?
… … Numbness or tingling in leg (s)
… … Frequent or severe HEADACHES ?

if "Yes" for headaches, describe attributes –

… Present for year
… Began recently
… Getting worse
… Getting better
… Last minutes
… Last hours or more
… Throbbing
… Band – like

Accompanied by –

… Nausen
… Stuffy nose

…Front
…Back
… Left side
…Right side
… All over head
… Location varies
… Worse when tired
…Worse when tense

…Neck pain
…Blind spots

EYES Do you have or have you had

Yes No.
… … Normal vision without glasses ?
… … Visual problem corrected with glasses ?
… … Visual problem not corrected with glasses ?
… … Nearsighted ?
… … Farsighted ?
… … Squint cross-eyed

… … Colorblindness ?
… … Blind right eye?
… … Blind left eye ?
… … Persistent pain right eye ?
… … Persistent pain left eye ?
… … Persistent watering of itching of eyes ?
… … Double vision
… … Ever had a serious eye injury ?

HEART AND LUNGS DO you have or have you had –

Yes No
… … Heart valve problems ?
… … Heart murmur?
… … Irregular heartbeat, skipped bets ?
… … Boults of heartbeat so fast you can't count ?
… … Enlarged heart ?
… … Frequent or persistent wheezing ?
… … Frequent persistent cough?
… … More susceptible to colds than friends ?
… … Frequent or severe CHEST PAIN?

"YES" for chest pain, describe attributes -

Present for years
Began recently
Sharp, knife – like
Dull ache, pressure
Present at rest
Worse with
Exercise … Deep breathing

… Chest motion … Nervousness
… Accompanied by numbness in hands or lips
… Accompanied by shortness of breath
… Relieved by rest
… Painful area is sore to touch
… Yes No.
… … … Do you have or have you had frequent or severe

SHORTNESS OF BREATH ?

If "Yes " for shortness of breath, describe attributes -

… Present for years
… Began recently
… Worse with exercise
… Present at rest
… Relieved by resting
… Occurs with chest pain
… Accompanied by wheezing
… Accompanied by coughing

EARS, NOSE, AND THROAT Do you have or have you had

Yes	No.	
…	…	Hearing loss right ear ?
…	…	Hearing loss left ear ?
…	…	Frequent ear aches ?
…	…	Sore or itching ear canals ?
…	…	Frequent stuffy or runny nose ?
…	…	Sinus trouble with stuffy nose, headache?
…	…	Frequent sneezing?
…	…	Nosebleeds not due to injury ?

DIGESTIVE Do you have or have you had

Yes	No	
…	…	Frequent nausea or vomiting ?
…	…	Vomiting of blood ?
…	…	Hot burning fluid in throat or chest?
…	…	Black tarry stools?
…	…	Frequent diarrhea or watery Stools?
…	…	Frequent constipation?
…	…	Bright red blood in stools ?
…	…	Persistent rectal itching or soreness ?
…	…	Frequent or severe HEARTBURN or INDIGESTION?

If "Yes" for indigestion, describe attributes –

… Present for years …….. Worse with
… Began recently Spicy foods
… Worse between meals (pepper)
… Worse after eating … Worse with oil foods
… Accompanied by per abdominal pain
… Accompanied by gas
… Relieved by milk or gelusil
… Relieved by drinking milk

Yes	No	
…	…	Do you have or have you frequent or severe ABDOMINAL PAIN ?

If "Yes" for abdominal pain describe attributes

Present for years
… Began abdomen
… Upper abdomen
… Lower abdomen
… Right, side
… Left side

… Dull ache
… Cramping
… Sharp, knife-like
… Burning
… Worse with eating
… Worse with not eating

Accompanied by -
… Menstrual periods (females)
… Urinary burning
… Diarrhoea
…Constipation

URINARY Do you have or have you had –

Yes	No	
…	…	Bedwetting problem?
…	…	Loss or urine control ?
…	…	Awaken from sleep to urinate frequently?
…	…	Urinate more than 10 time a day ?
…	…	Frequent urinary burning sensation ?
…	…	Blood in urine ?
…	…	Dark or coffee-colored urine ?
…	…	Pain in flank accompanied by fever ?
…	…	Abdominal pain with urination?
…	…	Trouble getting urine started?

WOMEN (Men go on to next section)

Do you have or have you had -

Yes	No	
…	…	Hard lump in breast
…	…	Vaginal infection or discharge?
…	…	Vaginal area pain with intercourse?
…	…	Irregular periods?
…	...	Excessive bleeding with periods?
…	…	Never had periods?
…	…	No longer having Periods?
…	…	Pregnant now?
…	…	Have been PREGNANT?

If "Yes" to current or past pregnancy, Specify details

… Number of Pregnancies
… Number of C-sections
… Number of miscarriages (spontaneous)
… Number of abortions
… Number of stillborns

MUSCULOSKELETAL Do you have or have you had -

…	…	Frequent or severe neck pain ?
…	…	Frequent or severe back pain ?
…	…	Painless swelling of feet or lower legs?
…	…	Stiffness in joint due to injury?
…	…	Stiffness in joint NOT due to injury?
…	…	Joint pain to injury
…	…	Persistent JOINT PAIN NOT due to injury?

If Yes for joint pain NOT due to Injury, describe

… Present for years
… Began recently
… Worse with exercise
… Worse after rest
… Involving hands
… Involving wrists
… Involving elbows
… Involving Shoulders
… Involving hips
… Involving knocks
… Involving ankles
… Involving feet
… Accompanied by redness
… Accompanied by swelling
… Accompanied

MEN (Women go on to next section)

You have or have you had

… … Enlarged or infected prostate?
… … Pus or drainage from penis?
… … Rupture or swelling in groin?
… … Frequent pain in testicle (s)?
… … Nodule in testlele growing larger?
… … Testlele absent or removed?
… … Problem with impotence?

OTHER SYSTEMS Do you have or you had

Yes No

… … Unexplained fever or chills?
… … Frequent or constant thirst
… … Weight loss not explained by diet?
… … Weight gain not explained by diet?
… … Constant fatigue?
… … Fatigue that comes and goes?
… … Weakness or fatigue between meals?
… … Skin lesion that won't heal?
… … Persistent rash or pimples
… … Dry skin or brittle nails?

Yes No.

… … Feel cold when others are warm?
… … Generally pale?
… … Skin or whites of eyes turning
… … yellow?
… … Swollen or tender glands or nodes?

FEELINGS are you, or do you generally –

Yes No.

… … Feel sad, despressed?
… … Feel lonely?
… … Cry without apparent reasons?
… … Wish to end it all?
… … Plan a way t kill self?
… … Unable to concentrate on anything?
… … Awaken, can't go back to sleep?
… … Still tired a night's sleep?
… … Feel tense and anxious?
… … More nervous than your friends?
… … Worry a lot about health?
… … Worry a lot about generally?
… … Have trouble falling asleep?
… … Jump at sudden noises and shake badly?
… … Have frightening thoughts?
… … Often break out in coldsweats?
… … Unsually afraid of high places?
… … Unsually afraid of closed places?
… … Unsually afraid of crowds?
… … Suffer from nervous exhaustion?
… … Get upset easily, highly irritable?
… … More touchy than your friends?
… … Tend to go to pieces if you don't constantly exert control over yourself ?
… … Get angry when told what to do?
… … Feel more violent than your friends?
… … Have a violent temper?
… … Get upset when things are not precise and orderly?
… … Do things mostly on impulse?
… … Feel it is OK to steal as long as no one nets hurt or caught?
… … Feel overly shy, sensitive?
… … Get feelings hurt easily?
… … Greatly upset by criticism?
… … Tremble or feel weak whenever someone shouts at you?
… … Get nervous or shaky when spp-roached by a superior?
… … Get completely mixed up when you have to do things quickly?
… … Afraid to be alone?
… … Usually wish you had someone to advise you?
… … Have feelings of inadequacy ?
… … Have strong feelings of dependency?
… … Seem to be more aggressive than your friends?
… … Have legal problems?
… … Have marital problems?
… … Have family problems?
… … Have sexual problems?
… … Have questions about sexual matters?
… … Feel someone is out to "get" you?
… … Hear voices when no one is around?
… … Feel someone is controlling you in an unusual way?
… … Feel you are responsible for the
… … Feel you are responsible for the sins of the world?

Yes No

… … Do you have any other problems Not covered by this questionnaire?

CONCLUSION

Thanks you for completing the questionnaire
Please check back through to make sure you Haven't skipped any sections or pages.

Please give us your opinion of this system

……. Very good
……. Good
……. Generally good, criticism minor
……. Don't like it.

- OBAFEMI AWOLOWO UNIVERSITY,
HEALTH CENTRE,
ILE-IFE.

STUDENT HEALTH SERVICE

ENTRANCE MEDICAL EXAMINATION

(To be completed by the Student, Please print)

(a) Surname…… Other Names ……. ……..
Date of Birth…….. Sex…….Single/Married……
Nationality……Ethnic Origin……
Faculty and Subjects …….
Name, Address, Telephone Number of Parent/Guardian/Next of kin…….....
……..

(b) Have you ever had or do you now have any of the following: Where yes, please give details.

	YES	NO		YES	NO		YES	NO
Arthritis			G.C.			Migraine		
Asthma			Genio-Urinary Disease			Parasitic/ Worm Disease		
Bone, Joint Disease Other Deformity			Hay Fever			Poliomyelitis		
Bronchitis			Headache (recurrent)			Rheumatic Fever		
Diabetes			Heat Disease			Skin Disease Incl. Leprosy		
Eye, Ear, Nose, Throat trouble			High Blood Pressure			Stomach or Duodenal Ulcer		
Dizziness or Fainting			Jaundice			Tuberculosis		
Drug Sensitivity			Kidney Disease			Schistosomiasis		
Dysentry			Liver of Gall Bladder Disease			Others (Specify)		
Epilepsy/Fits			Malaria					
Filariasis			Menstrual Disorders					

……

……

(c) Did you or do you smoke?..... Since when …….……..
What quantity per day?..... .....
(d) What activities do you enjoy in your spare time? ……..
Do you take part in any athletic pursuits? Regularly/Occasionally/Rarely/Not at all.
Did you represent you School at any Sports?.....If so which?.....
……
(e) Do you get very anxious at the time of class tests/exams?.....
(f) Have you ever received counseling/treatment for emotional disturbances, nervous disorders or mental illness?.....……
(g) Give details of any serious illness, injuries and accidents, fractures or operations you have had……..
……
(h) Give details of any previous admission into hospital as an in-patient for causes other than in (g) above……
……
(i) State any current medical/surgical/Psychiatric treatment you may be receiving……
……..
(j) Has any member of your family or a close relative suffered from Tuberculosis, diabetes, or Mental/Nervous disease?.....……
Please give details……..……
(k) Have you been immunized against:

	YES / NO	DATE(S)		YES / NO	DATE(S)
Poliomyelitis		Typhoid			
Small Pox		Yellow fever			
Tetanus		Others			
Tuberculosis					

I certify that the above history is true to the best of my knowledge.

CONFIDENTIAL

PHYSICAL EXAMINATION

PART II (To be completed by a Doctor at The Obafemi Awolowo University Health Centre)

(a) Height…….Weight……..Nutritional State: Thin/Average/Obess

(b) (i) Distant Vision (Snellens or similar Test-Type)
Without Glasses R . 6/ L. 6/
Corrected/ with Glasses: R . 6/ L. 6/

(ii) Colour vision: Normal/Abnormal

(c) Hearing: Right ear
Left ear

(d) Pulse (Rate etc)
Blood Pressure:
Systonlic
Diastolic

(e) Clinical examination: Describe any important abnormality, please

		Normal	Abnormal
Head and Neck			
Conjuctivate & Mucous Membranes			
Tongue			
Teeth & Throat			
Ear, Nose and simuses			
Lymph Glands			
Chest and Lungs			
Heart			
Abdomen			
Haemorrhoids or Fistula			
Genito-Urinary (Including Hernial Orifices)			
Nervous System	Pupilary reflexes Spinal reflexes		
	Protein		
Urine	Sugar		
	Others		

(f) Stool Examination Parasites:…….
Occult Blood:……..

(g) Blood Hb%.....P.C.V…….
W.B. C. & Differential……

(h) Place, Date, Number and Report of Chest X-ray (The X-ray picture must be taken at Obafemi Awolowo University) ……

(i) Summary of Significant abnormalities……..……
……
……

(j) Assessment: I have today examine Mr/Mrs/Miss……..
and He/She is/is not, in my opinion, free from physical defect, organic or nervous ailment or their after-effects likely to impair or disturb mental and physical activity in a University. He is free/not free from infectious diseases.
I assess his health and physical condition as Excellent / Good / Fair / Poor

(k) She is / is not pregnant.

Date:……..Signature of the Physician……
Name…….……
Address…….……
……..

PART III (To be completed by the University Medical Officer)

Tubercumn Test (Mantoux /Heal):

Remarks:……
Date:……..