



**MC1 – NTU Health Screening Form (Part I)**

**PART I: CONFIDENTIAL MEDICAL HISTORY** (To be completed by the student)

**GRADUATE**

PERSONAL PARTICULARS							
Full Name (Block Letter): _____		Sex: _____					
Application No.: _____		NRIC No./Passport No.: _____					
Date of Birth: _____		Citizenship: _____					
Programme of Study: _____		Mobile No.: _____					
PERSONAL HISTORY	NO	YES	If yes, give details & dates				
<b>1. NERVOUS SYSTEM/PSYCHIATRY</b> Frequent headaches, migraine, giddiness, fainting spells, epilepsy (fits), multiple sclerosis, nervous breakdown, anxiety disorder, depression, phobias, substance dependency, eating disorder, treated by psychiatrist or seen a counsellor before.							
<b>2. EYE, EAR, NOSE, THROAT</b> History of seeing black spots, bright lights, blur vision, hearing problems, ear infection, hearing loud noises (tinnitus), constant running nose, sneezing, blocked nose, nose bleeding.							
<b>3. RESPIRATORY SYSTEM</b> Asthma, frequent cough, tuberculosis, shortness of breath on and off.							
<b>4. CARDIOVASCULAR SYSTEM</b> Chest pain, palpitations, high blood pressure, heart murmur.							
<b>5. GASTROINTESTINAL SYSTEM</b> Gastric problem, frequent diarrhoea, constipation problem, stomach ulcer, abdominal pain on and off, bloatedness, piles (haemorrhoids).							
<b>6. GENITAL-URINARY SYSTEM</b> Sugar, protein or blood in urine, past urinary tract infection, kidney problem, testicular lumps (males only), hernia, sexually-transmitted infections.							
<b>7. ENDOCRINE SYSTEM</b> Thyroid problem, diabetes							
<b>8. MUSCULO-SKELETAL SYSTEM</b> Frequent backache, knee pain on and off, frequent ankle sprains, neck problem, shoulder problem, gout, previous fracture.							
<b>9. SKIN</b> Eczema, urticaria, fungal infection, psoriasis							
10. Any serious injuries, hospitalisation, operation							
11. Are you a Hepatitis B carrier?							
12. Any disability, impairment or special needs or illness/condition not mentioned above?							
<b>13. FOR FEMALES ONLY</b> History of breast lump, menses problem eg. irregular menses, menses pain, etc							
FAMILY HISTORY	NO	YES	If yes, give details & dates	SOCIAL HISTORY	NO	YES	If yes, give details & dates
1. Hypertension				1. Cigarettes			No. of cigarettes/day: No. of years:
2. Heart Disease							
3. Stroke				2. Alcohol			
4. Diabetes				<b>DRUG HISTORY</b>	<b>NO</b>	<b>YES</b>	<b>If yes, give details &amp; dates</b>
5. Tuberculosis				1. Drugstaken presently			
6. Mental Disorder				2. Allergy			
7. Others							

**Data Protection Information**

Your health records are held in confidence by the Medical Centre at NTU. Your school will be informed if there is a need to make adjustments for you if it is relevant to your educational needs or if it affects the safety of the people you work with. You may obtain access to your health record by contacting the Medical Centre at NTU.

**Declaration**

I hereby declare that I have not withheld any relevant information or made any misleading statement. I consent to my information being held and processed by the Medical Centre at NTU as described in the 'Data Protection Information' above.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

# MC1 – NTU Medical Examination Form (Part II)

NANYANG TECHNOLOGICAL UNIVERSITY

GRADUATE

## PART II: REPORT OF MEDICAL EXAMINATION

(To be completed by a Registered Physician)

SIGNIFICANT MEDICAL HISTORY (including psychiatric disorders):	
PHYSICAL EXAMINATION	
Height: _____ m	Weight: _____ kg
Vision: _____	Colour Vision: _____
Blood Pressure: _____ Pulse Rate: _____	
Cardiovascular System: _____	
Respiratory System: _____	
Abdomen (Note presence of hernia): _____	
Central Nervous System: _____	
Musculoskeletal System: _____	
Others: _____	
INVESTIGATION	
Urine Protein: _____	Sugar: _____
Others: _____	
Chest X-ray Report: For LKC Medicine students and all International Students only which should be done within the last 3 months and film should be attached if done overseas.	
OTHERS	
Is patient now under treatment for any physical/emotional condition?	
Do you have any recommendation regarding the care of this student?	
Any drug allergy?	

I certify that I have this day examined the abovenamed and the results of medical examination are as set forth. In my opinion, he/she is found to be in good health and free from any physical defect, organic or nervous ailments or after effects thereof which might render him/her unfit to pursue or complete his/her university programme of studies.

Physician's Signature  
Address:

Name & Professional Qualifications

Date