OFFICE OF PRINCIPAL TVET INSTITUTE

P. o Box 4658 – 01002 Thika. Mob: + 254 798 468 256

email: info@tvet.umma.ac.ke , principal@tvet.umma.ac.ke website: www.umma.ac.ke

MEDICAL EXAMINATION FORM

1. **PERSONAL HISTORY**

Surname:……Other names:……ADM.No…… … Date of birth…….. Place of birth…….. Next of kin Relationship:……
Address:……Mob No…….

2.**SOCIAL HISTORY** (Indicate 'x' where appropriate)

Alcohol: YES…….NO…….. HOW OFTEN (if yes) ……

Tobacco: YES…… NO……. HOW OFTEN (if yes) …… ……..

Regular doctor's medication: YES……..NO……. Which one……. …….

History of mental illness: NO……..YES……If yes give details below
……
..……

Have you been suspended from school? NO……YES……If yes give details
……
……

Do you suffer from any chronic illness? NO……..YES…….. if yes, which one:

( ) Diabetes, ( ) Hypertension, ( ) Tuberculosis, ( ) Hepatitis, ( ) sickle cell disease, ( ) leukemia

Have you had any of these symptoms for more than one week? () fever, ( ) Cold Chills, ( ) Weight Loss, ( ) Diarrhea, ( ) Vomiting.

Do you have any known food or drug allergy? If yes specify,
…… ……

…….

……

3**. FAMILY HISTORY** Do any of your relatives suffer from?

( ) High blood pressure ( ) Diabetes, ( ) Heart Disease, ( ) Allergies, ( ) Mental illnesses, ( ) Epilepsy, Other, please specify……

4. GENERAL EXAMINATIONS (To be examined in a government hospital)

General appearance: …….. Weight:…….

Height ……Respiratory System: inspiration……

Expiration……..

Cardiovascular System: pulse ……./mm B/P. Heart sounds…….

Genito Urinary……..

Ears/Nose/Throat …….

Skin……Sight……....

Sight retraction R/E ……... L/E…….

5. LABORATORY EXAMINATION (Attach lab reports)

Hemogram E.S.R V.D.R.I. Blood group

Chest X-ray P/A (let your doctor decide if it's necessary) attach only radiologist report.

Urinalysis (PT for females) …… Mantoux test (PPC)…….

STATE PREFERRED HOSPITAL FOR MEDICAL ATTENTION. Tick your choice.

a. **AMA HEALTH CENTRE**
b. **THIKA LEVEL 5 HOSPITAL**
c. **ST. MULUMBA'S HOSPITAL**
d. **MAKONGENI HEALTH CENTRE**
e. **OTHER** ……

6. FOR DOCTORS USE ONLY (Government Hospital Official stamp should be included)

Medic's Name……. Signature…….

Qualification……. Date……

6. PERSONAL DECLARATION

I hereby consent to offer this information to any medical authority as deemed necessary to effect quick treatment.

Student Name……. Sign……. Date…….