MUSLIM UNIVERSITY OF MOROGORO

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MEDICAL EXAMINATION REPORT

(To be filled by registered Medical Practitioner)

Admission to Muslim University of Morogoro is conditional upon a satisfactory medical report. The report should be addressed to:

The Deputy Vice Chancellor (Academic),
Muslim University of Morogoro,
P.O. Box 1031,
MOROGORO.

1. STUDENT PARTICULARS:

First name: …… Middle name: …….. Surname: ……..

Sex: …… Program selected: ……..

Marital status (currently): …… Date of Birth: ……/……/……...

Address: ……..……..

2. (A) PAST MEDICAL HISTORY:

History of suffering from the following medical conditions

❖ Diabetes	YES/NO	❖ Tuberculosis	YES/NO
❖ Hypertension	YES/NO	❖ Asthma	YES/NO
❖ Seizures/ Epilepsy /Convulsion	YES/NO	❖ Sickle cell diseases	YES/NO
❖ Peptic ulcer diseases	YES/NO	❖ Mental illness	YES/NO
❖ Allergic to: - Foods/ Medication	YES/NO	❖ Others (specify	YES/NO

✓ Remarks for above conditions: "If the answer is YES" (include date & details, like how was diagnosed, medication and any attachment if any)

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✓ Current medications/clinic visits:

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(B) PAST SURGICAL/ MAJOR TRAUMA HISTORY.

- History of major surgery (YES/NO)
  - If YES: (Give details what type of surgery, when, outcome, and current condition)
    ……
    ……
    ……
- History of major accident/ trauma in past (YES/NO)
  - If YES: (Give details what part of the body affected, when, outcome, and current condition)
    ……
    ……
    ……

Student declaration: I…….declare to the best of my knowledge that all the Information concerning my past medical history are correct.

Student signature: ……..

3. PHYSICAL EXAMINATION

A) GENERAL EXAMINATION

VITAL SIGNS	REMARKS	OTHERS	REMARKS
1. Blood pressure(BP)…… MmHg 2. Pulse Rate(PR) ……Bpm 3. Respiration Rate(RR)…… Brpm 4. Oxygen saturation (SP02)……%		5. Body weight (Bwt)…….Kg 6. Body height: (Bht)…… Cm 7. Body mass index (BMI)……	

B) SYSTEMIC EXAMINATION:

- NEUROLOGICAL EXAMINATION:

TYPE OF EXAMINATION	AREA TO EXAMINE	REMARKS
COGNITIVE FUNCTIONS	❖ Orientation ❖ Memory ❖ Concentration ❖ Thinking	

- **VISION**
  Visual acuity:
  - ❖ Without glasses R: ……/…… L: ……./……..
  - ❖ With glasses (For those with refractive errors) R: ……/……. L: ……. /……
  - ❖ Squint ……
- **HEARING: Rt Ear: …….. Lt Ear: ……..**
  - ❖ **OTOSCOPIC EAR EXAMINATION:**
    - ✓ External auditory canal: ……Ear drum ……
    - ✓ Any neurological deficit? ……..

- **MUSCOSKELETAL:**
  - ✓ Any deformity YES/NO. If YES which part: ……
  - ✓ Use of accessories/Aids YES/NO. If YES which kind of: ……
- **CARDIORESPIRATORY;**
  - ✓ Heart sounds; ……Breath sounds: ……
  - ✓ Rhythm …… ECG? …… SPIROMETRY? ……
- **GASTROINTESTINAL;**
  - ✓ Oral examination: …… Dentition: …… Any implant: ……
  - ✓ Any organomegaly: ……
  - ✓ Any Hernia: ……..

REMARKS:

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……
……

4. LABORATORY INVESTIGATION/TEST

✓ ABO/Rh Blood grouping; she/he is blood group

Done by: Lab scientist/technician; signature:

Date: ……

5. ANY OTHER DOCTOR'S REMARKS:

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……
……
……..

DOCTOR'S NAMES: **MCT REGISTRATION NUMBER:**

DESIGNATION: **SIGNATURE:**

Hospital stamp: ……