PRECIOUS CORNERSTONE UNIVERSITY
OLD IFE ROAD, IBADAN, OYO STATE

MEDICAL EXAMINATION REPORT

PART A: TO BE FILLED BY THE CANDIDATE/STUDENT

1. Name in full (Surname first)……
2. Data of Birth …….
   Address ……..
3. Gender……
4. Previous Operations with dates if any……..

   ……

   Previous Injuries/Accidents, etc. with dates ……

Vaccinations and Inoculations with latest dates:

Small Pox…… Triple Vaccine (D.P.T.) ……

Polio……. Typhoid ……

Yellow Fever…… Cholera …….

Any others……

5. Family Medical History
   Parents/Other close Relations
   Heart Disease……
   Kidney Disease……
   High Blood Pressure……
   Diabetes……..
   Nervous ill-health……
   Mental ill-health……

6. Any other health defect, e.g. sight or hearing impairment and whether or not adequately corrected compensated.

   ……

7. Have you been treated for nervous or mental ill health before or currently undergoing treatment?

I certify that to the best of my knowledge and belief the above are correct.
Candidate's Signature…… Date…….

PART B PHYSICAL EXAMINATION

(To be completed by Medical Doctor)

(i) Height……. Weight……

Central Nervous System Papillary reflexes spinal reflexes

Special Senses……

Cardiovascular System

Heart (Size and Position)……

Heart Sound……

B.P

Pulse

Gastro-Intestinal System……

Liver

Spleen

Hernia

Hemorrhoid/Fistula

Visual Activity

Without glasses R6/5 L6/Similar Test Type

With glasses R6/ L6/Similar Test Type

Genito urinary system kidneys……

Hearing Left…….

Hearing Right……..

Other Physical Observation

Eyes

Ears, Nose and Sinuses……

Throat……..

Lymphatic glands……

Chest……..

Muscular Skeletal System……..

C) Laboratory Examinations

Blood Group……

Genotype……

P.C.V……

(ii) Special Investigations

a. Chest X-Ray (report and film to be submitted)
……

b. Tuberculin Test (Monteux) ……

c. HIV/AIDS test……

d. Hepatitis ……..

(iv) Assessment of Mental Health
……

(v) Additional Observation/Remarks
……
……
……
……
……

Assessment: I have today examined……

And He/she is not in my opinion free from physical defect, organic or nervous ailment or their effects likely to impair or disturb mental and physical activity in a University.

He / She health and physical condition as Excellent/Good/Poor.

Date: ……

Signature of Physician……

Full Name: ……

Address: ……

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