UNIVERSITY OF NAIROBI

STUDENT ENTRANCE MEDICAL EXAMINATION

REGISTRATION NO ……

IMPORTANT.

Students are required to complete Part I of this form .Part II should be completed with the help of the doctor but signed by the student. Part II should be completed and signed by the examining doctor. The examination doctor is required to complete the form truthfully. He She should, at the end of part III print his/her name together with his/her Medical practitioners&Dentists Board registration number as queries regarding the student on the completed form may be directed to that doctor if it is deemed necessary. The completed form MUST be handled in at the time of registration to the Chief Medical Officer, University of Nairobi Health Services, P.O Box 30197, Nairobi, Kenya.

Students must identify themselves with a student identity card at the University Health Services. Medical services are provided only when students are in session. In-patient services are available at the University sick-bay and KenyattaNational Hospital or services sourced outside these facilities will not be paid for by the University, nor does the student Medical Scheme cover dental, eye treatment, eye glasses, pregnancy, childbirth and their complications.

PART I:

SURNAME …….. OTHER NAMES …… SEX ……

DATE OF BIRTH ……PLACE OF BIRTH ……

NATIONALIUTY ……...MARITAL STATUS …… NO. OF CHILDREN ……

FACULTY…….

NAME OF PARENT/GUARDIAN/NEXT OF KIN ……

POSTAL ADDRESS ……

TELEPHONE NO. (HOME) …… OFFICE ……..

PART II: (To be completed by the student with the doctor's help)

Have you ever been admitted to the hospital? ……

If so, when and for what illness? ……..

Have you ever suffered from any of the following?.....

Allergy	Yes/No	Infectious Mononucleosis	Yes/No
Anaemia	Yes/No	Jaundice Hepatitis	Yes/No
Asthma	Yes/No	Peptic Ulcer	Yes/No
Back problem	Yes/No	Mental illness	Yes/No
Bilharzia	Yes/No	Poliomyelitis	Yes/no
Bladder problem	Yes/No	Severe headaches	Yes/No

Chest infection	Yes/No	Surgery	Yes/No
Diabetes mellitus	Yes/No	Thyroid disease	Yes/No
Epilepsy	Yes/No	Tuberculosis	Yes/No
Eye problem	Yes/No	Speech problem	Yes/no
Heart disease	Yes/No	Hearing problem	Yes/No
High blood pressure	Yes/No	Sexually transmitted disease	Yes/No
Blood transfusion	Yes/No	Irregular menstrual periods	Yes/No
Are you on any treatment now?	Yes/No	HIV infection	Yes/No
		AIDS	Yes/No

If the answer to any of the above is YES, please give details …….

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……

Who's your doctor? ……..

FAMILY MEDICAL HISTORY:

Has any member of your family suffered from any of the following?

Diabetes mellitus	Yes/No	Heart disease	Yes/No
Bronchial asthma	Yes/No	High blood pressure	Yes/no
Mental illness	Yes/No	Sickle cell disease	Yes/No
Tuberculosis	Yes/No		

SIGNATURE …… **DATE** ……..

AUTHORIZATION STATEMENT

I hereby authorize any doctor, clinic or medical provider, any insurance company, institution any person who has any record or information about me and/ or any of my family members to provide University of Nairobi with complete information including copies of their records with reference to my sickness or accident, any treatment, examination, advice or hospitalization. Any photocopy of this authorization shall be taken as the original copy.

PART III: (To be completed by the Examination Doctor) ……

Immunization record ……

Height …….. Weight ……. Any deformity …….

Visual acuity …….LE 6 ……RE 6 ……..

Hearing …… Nose …….. Throat …….

Lymphatic glands ……..

CARDIOVASCULAR SYSTEM.

Pulse ……../minute Regular/irregular ……

Heart sounds …….. Blood pressure …….

RESPIRATORY SYSTEM:

Chest X- ray ……

……

ALIMENTARY SYSTEM:

Teeth ……. Tongue …… Abdominal ……..

GENITO-URINARY SYSTEM:

Urethra discharge …….. L.M.P …… Uterus ……

Urine …….. S.G ……Albumin …….. Sugar ……..

Deposit ……..

HIV test ……

COMMENTS BY THE EXAMINING DOCTOR:

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……

DOCTOR'S NAME (printed) …… SIGNATURE ……..

MEDICAL PRACTIONERS & DENTISTS BOARD REG. NO. ……... DATE …….

PART IV:

COMMENTS BY THE UNIVERSITY CHIEF MEDICAL OFFICER:

Special remarks ……

……

Does the student require any special medical needs? ……...

……

CHIEF MEDICAL OFFICER

UNIVERSITY HEALTH SERVICES **DATE** …….