UNIVERSITY OF ABUJA

STUDENT MEDICAL HISTORY AND SCREENING FORM

Undergraduate and postgraduate students are requested to complete Part I of this form. Part II should be complete at the University Medical Centre. The form should be returned to the Director, University Medical Centre after completion.

The information will be treated in strict confidence.

The purpose is to screen for possible health problems and give guidance to encourage excellent health.

PART I (To be filled by the student)

General Information

Surname:	ADERIBIGBE	Other names:	Musodiq Olamide
Sex:	Male		
Date of Birth:	29/06/2001 (dd/mm/yyyy)		
Age at last birthday:	22		
Address:	1, Ahmadiyya Crescent, Ijaiye Ojokoro,		
Contact Phone Number:	08107183206	Nationality:	Nigerian
Ethnicity:	.....		
State of Origin:	Osun	Local Government Area:	Aiyedaade
Marital status:			
Faculty:	Social Sciences	Department:	Sociology
Reg.No:	202210745043EA		
Session of Enrolment into study:	2022/2023		

Past Medical History

Answer **YES or NO** and comment below.

Have you ever had or do you have any of the following health problems?

- **Cardiac**
  - High Blood Pressure ☐
  - Fainting episodes ☐
  - Heart Attack ☐
  - Heart Failure ☐
  - Palpitation ☐
- **Lung**
  - Sleep apnea ☐
  - Orthopnea ☐
  - Asthma ☐
  - Chronic obstructive pulmonary disease ☐
  - Tuberculosis ☐
  - Seasonal allergies ☐
  - Others: ……
- **Hemoglobinopathies**
  - Sickle cell disease ☐
  - Thalassemias ☐
  - Others: ……
- **G I**
  - Jaundice ☐
  - Liver disease ☐
  - Gall bladder disease ☐
  - Gastritis/Ulcer disease ☐
  - Acid reflux ☐
  - Haemorrhoids ☐
  - Others: ……
- **Kidney**
  - Kidney infection ☐
  - Bladder infection ☐
  - Kidney stones ☐
  - Others: ……
- **Substance use**
  - Alcohol ☐
  - Marijuana ☐

- Other drugs: ……
- **Diabetes mellitus** ☐
- **Thyroid disorder** ☐
- **Hepatitis** ☐
- **Dental disease** ☐
- **Glaucoma** ☐
- **High Cholesterol** ☐
- **Serious trauma** ☐
- **Neurological injuries** ☐
- **Neurology =**
  - Migraine headache ☐
  - Stroke ☐
  - Seizure ☐
  - Palsy ☐
  - Others: ……
- **Psychiatry**
  - Depression ☐
  - Anxiety ☐
  - Bipolar ☐
  - Eating disorder ☐
- **Environmental allergies** ☐
- **Bleeding tendency** ☐

  Comments if the answer to any of the above is YES, please give details with dates.

  ……

- **Surgeries**

  Type of surgery and specific date: ……

- **Hospitalizations**

  Name of Hospital, dates and reasons for hospitalization.

  ……

- **Medications**

  Are you on any prescription medications YES ☐ NO ☐ List the drugs you are currently taking

  ……

- **Allergies**

  List any drug that you have reaction to: ……

- **Family History**

  Does any member of your family (i.e. siblings, parents, grandparents) have these illnesses?

  - Heart attack
  - High blood pressure
  - Diabetes
  - Mental illness
  - Heart disease
  - Stroke
  - Migraines/headaches

- **Immunization History**
  - BCG - Date ……
  - CSM - Date ……
  - Tetanus - Date ……
  - Others - Date ……
- Birth weight (if known) ……
- Do you currently smoke? Yes ☐ No ☐
- For how long have you been smoking? Months Years
- Have you ever smoked in the past? Yes ☐ No ☐
- If no longer smoking, for how long have you smoked? Months Years
- If no longer smoking, how long ago did you stop? <1 yr ☐ >1 yr ☐ Don't know ☐ Not applicable ☐
- How many sticks of cigarette have you smoked in your life time? <100 ☐ >100 ☐ Don't know ☐ specify ☐
- **Gynaecology History (females only)**

  Do you have a period every month, YES ☐ NO ☐ Number of days of flow: ……

  Menstrual cramps: ☐ Mild ☐ Moderate ☐ Severe ☐ None

  Date…… Student's signature ……

PART II

(To be completed at the University Medical Centre)
Height …… meters. Weight …… Kg
Abdominal girth ……cm Birth weight.....Kg
Hip Circumference .....cm Arm Circumference.....cm

Visual acuity	R	L
Without glasses		
With glasses		
Hearing		

Eyes		
Ears		
Teeth		
Pharynx		
Lymphatic glands		

CNS:
CVS: Pulse rate
Blood Pressure
Heart Sounds
Respiratory System:
Abdomen:

Laboratory investigations

S/N	TEST	REMARKS
1.	Urinalysis	
2.	Stool Microscopy	
3.	PCV	
4.	Blood Group	
5.	Genotype	
6.	Mantoux test	
7.	HBsAg	
8.	HCV	

Chest X-ray (attach radiologist report) Name of Hospital: ……
Film No: ....
Radiologist report:
.....
Medical Doctor's Remarks: I have examined ..... and found him/her to be physically and mentally fit for studies.
Name of Medical Doctor: ……
Folio no.; MDCN/R/……
Doctor's signature, date and stamp.....