



MC1 – NTU Medical Check-up Form (Part I)

PART I: CONFIDENTIAL MEDICAL HISTORY (To be completed by the student)

PERSONAL PARTICULARS							
Full Name (Block Letter): _____		Sex: _____					
Application No.: _____		NRIC No./Passport No.: _____					
Citizenship: _____		Date of Birth: _____					
Programme of Study: _____		Mobile No.: _____					
PERSONAL HISTORY	NO	YES	If yes, give details & dates				
1. NERVOUS SYSTEM/PSYCHIATRY Frequent headaches, migraine, giddiness, fainting spells, epilepsy (fits), multiple sclerosis, nervous breakdown, anxiety disorder, depression, phobias, substance dependency, eating disorder, treated by psychiatrist or seen a counsellor before.							
2. EYE, EAR, NOSE, THROAT History of seeing black spots, bright lights, blur vision, hearing problems, ear infection, hearing loud noises (tinnitus), constant running nose, sneezing, blocked nose, nose bleeding.							
3. RESPIRATORY SYSTEM Asthma, frequent cough, tuberculosis, shortness of breath on and off.							
4. CARDIOVASCULAR SYSTEM Chest pain, palpitations, high blood pressure, heart murmur.							
5. GASTROINTESTINAL SYSTEM Gastric problem, frequent diarrhoea, constipation problem, stomach ulcer, abdominal pain on and off, bloatedness, piles (haemorrhoids).							
6. GENITAL-URINARY SYSTEM Sugar, protein or blood in urine, past urinary tract infection, kidney problem, testicular lumps (males only), hernia, sexually-transmitted infections.							
7. ENDOCRINE SYSTEM Thyroid problem, diabetes							
8. MUSCULO-SKELETAL SYSTEM Frequent backache, knee pain on and off, frequent ankle sprains, neck problem, shoulder problem, gout, previous fracture.							
9. SKIN Eczema, urticaria, fungal infection, psoriasis							
10. Any serious injuries, hospitalisation, operation							
11. Are you a Hepatitis B carrier?							
12. Any disability, impairment or special needs or illness/condition not mentioned above?							
13. FOR FEMALES ONLY History of breast lump, menses problem eg. irregular menses, menses pain, etc							
FAMILY HISTORY	NO	YES	If yes, give details & dates	SOCIAL HISTORY	NO	YES	If yes, give details & dates
1. Hypertension				1. Cigarettes			No. of cigarettes/day: No. of years:
2. Heart Disease							
3. Stroke				2. Alcohol			
4. Diabetes				DRUG HISTORY	NO	YES	If yes, give details & dates
5. Tuberculosis				1. Drugstakenpresently			
6. Mental Disorder				2. Allergy			
7. Others							

Data Protection Information

Your health records are held in confidence by the Medical Centre at NTU. NTU will be informed of the results of your health examination. If necessary, this information may be used to make adjustments to your academic or campus experience, particularly if it is relevant to your educational needs or impacts the safety of those you interact with.

Declaration

I hereby declare that I have not withheld any relevant information or made any misleading statement. I consent to my information being held and processed by the Medical Centre at NTU as described in the 'Data Protection Information' above.

Student's Signature _____

Date _____

MC1 – NTU Medical Check-up Form (Part II)

NANYANG TECHNOLOGICAL UNIVERSITY

PART II: REPORT OF MEDICAL EXAMINATION

(To be completed by a Registered Physician)

SIGNIFICANT MEDICAL HISTORY (including psychiatric disorders):

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PHYSICAL EXAMINATION

Height: _____ m Weight: _____ kg Vision: R 6/____ normal/ L 6/____ aided/unaided Colour Vision: partial red green deficiency - wire test Pass/ Fail

Blood Pressure: _____ Pulse Rate: _____

Cardiovascular System: _____

Respiratory System: _____

Abdomen (Note presence of hernia): _____

Central Nervous System: _____

Musculoskeletal System: _____

Others: _____

INVESTIGATION

Urine Protein: _____ Sugar: _____ Others: _____

Chest X-ray report: Only required for students pursuing LKC Medicine programs, Chinese Medicine, and for all International Students, which should be done within the last 3 months and film should be attached if done overseas.

OTHERS

Is patient now under treatment for any physical/emotional condition?

Do you have any recommendation regarding the care of this student?

Any drug allergy?

I certify that I have this day examined the abovenamed and the results of medical examination are as set forth. In my opinion, he/she is found to be in good health and free from any physical defect, organic or nervous ailments or after effects thereof which might render him/her unfit to pursue or complete his/her university programme of studies.

Physician's Signature
Address:

Name & Professional Qualifications

Date