BUSITEMA UNIVERSITY
Pursuing Excellence

MEDICAL EXAMINATION FORM

Name: ……... Sex…….Age…….
Date of birth:……Phone No……
Home address: ……Citizenship: ……..
Next of kin……Relationship……

(A) PHYSICAL EXAMINATION (To be completed a Medical Doctor)

Suggested laboratory tests:
Urinalysis ☐ Within normal limits ☐ Abnormal
Covid19 test ☐ Negative ☐ Positive
Hepatitis B test ☐ Negative ☐ Positive
If abnormal, explain:
……

S/N	Clinical Evaluation	Normal	Abnormal	Comments
1	Body Temperature			
2	Blood pressure and pulse			
1	Skin			
2	Head, ears, eyes, nose, throat			
3	Mouth, teeth, gums			
4	Neck and thyroid			
5	Lungs/chest			
6	Breasts			
7	Heart			
8	Abdomen			
9	Genitalia			
10	Back/spine			
11	Extremities/musculoskeletal			
12	Neurological			
14	Other findings			

(B) MEDICAL HISTORY: (To be completed by the student)
Please fill YES below if you have had or are currently under treatment for any of the following and fill No where applicable.

	Covid19		Emotional disorder		Reflux
	Anemia		Eating disorder		Hepatitis
	Diabetes mellitus		Drugs/alcohol abuse		Rectal bleeding
	Cancer		Depression		Hernia
	Sickle cell disease		Panic Anxiety disorder		Blood in urine
	Asthma		Shortness of breath with Exercise		Chronic kidney disease
	Pneumonia		Fainting with Exercise		STIs
	Tuberculosis		Mental disorder		Pelvic/Virginal infections
	Recurrent ear infection		Trouble sleeping		Ulcer
	Heart Disease		Bone fractures		Testicular lump
	Congenital condition		Joint injury		Testicular torsion
	Rheumatic Heart Disease		Arthritis		Acne/pimples
	High Blood Pressure		Back pain/problems		Chronic rash
	Heart Palpitations		Neurological disorder		Menstrual history
	Chest pain		Head injury with loss of consciousness		Painful periods
	Thyroid Disorder		Fainting/dizziness		Heavy flow
	Disability		Seizure disorder/convulsions		Irregular periods
	Vision problems		Recurrent Nose Bleeds		Age of 1st period
	Hearing problems		Recurrent sinusitis		Pregnancy
	Locomotive problems		Hearing loss		Serious accident/injury
	Migraine headaches		Hepatitis B		Other conditions

Do you use tobacco?

☐ Yes ☐ No If yes, Number of packets/day ☐

Do you drink alcohol?

☐ ☐ No If yes, amount/week

Explanation for any positive answers above

……

……

Allergy to medications/X-ray dyes, please list all

……

Allergy to food/environment/insect allergies please list all

…….....

Have you been close to somebody who has been diagnosed for covid19 in the last two weeks?

……..

Family History

Have any of your relatives ever had any of the following?

	Yes	No	Relationship		*Yes*	*No*	Relationship
Alcoholism				Stomach disease			
Tuberculosis				Mental illness			
Arthritis				Sudden death (non traumatic)			
Asthma				Epilepsy, Convulsions			
Diabetes				Heart Disease			

Surgeries

☐ Appendectomy ☐ Tonsils ☐ Hernia repair

Others: (Specify)

……

……

……

Current medications and dose as prescribed by your physician

……

……

……

Loss of paired organ function ☐ ☐

If yes, please explain:

……

……

……

Recommendation for physical activities, including participation in club and inter- university

Sports ☐ Unlimited ☐ Limited

If limited, please explain:

……

……

GENERAL RECOMMENDATIONS AND OBSERVATIONS:

……

……....

EXAMINING DOCTORS NAMES:

……

PLACE OF EXAMINATION:

……....

DATE OF EXAMINATION: ……

REGISTRATION NUMBER: ……

DOCTORS SIGNATURE AND STAMP:

……