ABUBAKAR TAFAWA BALEWA UNIVERSITY BAUCHI

Our Ref: ATBU/ACAD/GEN/MC/004

P. M. B. 0248
Bauchi, Nigeria
077-542095
543500

ABUBAKAR TAFAWA BALEWA UNIVERSITY, BAUCHI

MEDICAL EXAMINATION FORM FOR PROSPECTIVE STUDENTS

All 2015/2016 Admitted Students are requested to complete **Part I** of this form and then present it to a qualified Medical Practitioner who will carry out Medical Examination and complete **Part II** of the Form. The information supplied will be treated as confidential.

Thereafter, the form should be returned to the **Medical Director Abubakar Tafawa Balewa University, Bauchi**,

PART I (To completed by the Student)

i) Full Name:----------

ii) Reg. No.: ----------

iii) Department: ---------- --

iv) Faculty----------

v) Date of Birth: ----------

vi) Sex:----------

vii) Marital Status:----------

viii) State of Origin:----------

ix) Nationality:----------

x) Contact address:----------

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xi) Phone No.----------

Personal Health History (Just thick)

Have you ever been admitted into a hospital as in-patient? Yes { } No { }

(If the answer is Yes, state reason, duration name of the hospital and date)

Are you suffering from any of the following:

Tuberculosis	Yes { } No { }	Epilepsy	Yes { } No { }
Hypertension	Yes { } No { }	Peptic Ulcer	Yes { } No { }
Pile	Yes { } No { }	Diabetis	Yes { } No { }
Diarrhea	Yes { } No { }	Gonorrhea	Yes { } No { }
Hepatitis	Yes { } No { }	Any other disease	Yes { } No { }

Have you been immunized in any of the following:

Cerebrospinal Meningitis (CSM) Yes { } No { } Date:----------

Tetanus Yes { } No { } Date:----------

Yellow Fever Yes { } No { } Date:----------

Hepatitis Yes { } No { } Date:----------

Give further details of your health history not covered by above questions:

PART II (To be completed by the Doctor)

Height----------Metres

Weight:----------Kilogrammes

VISUAL AQUITY

Without glasses

R. 6/6:----------

L. 6/6:----------

HEARING

Left:----------

Right:----------

Condition of Ear drums:----------

CIRCULATORY SYSTEM

Heart Sound:----------

Pulse----------

Blood pressure:----------

RESPIRATORY SYSTEM

ABDOMEN

Liver:----------

Spleen:----------

Hernia:----------

CENTRAL NERVOUS SYSTEM

CHEST X-RAY:----------

URINE ANALYSIS

Albumen:----------

Sugar:----------

BLOOD

Blood Group:----------

Genotype:----------

Random Blood Sugar(RBS):----------

VDRL:----------

Additional comment by the Medical Practitioner:----------

Name of Doctor: ----------

Signature: ----------

Reg./No. ----------

Address: ----------