

## **MEDICAL EXAMINATION FORM**

### **TUMAINI UNIVERSITY**

#### STEFANO MOSHI MEMORIAL University College

P.O. Box 881 Moshi, Tanzania

TEL: (0)27 2757070, FAX: (0)27-2757880 EMAIL: elctmmti@yahoo.com WEBSITE: www.smmuco.ac.tz

This form consists of Section A to be completed by the applicant and Section B to be completed by a registered medical officer. The completed form must be submitted along with all the other application materials.

# SECTION A (TO BE COMPLETED BY THE APPLICANT)

Place   First   Middle:   Last:   Marrial Status   Programme   Middle:   Marrial Status							
Full Name Date of Birth Gender Programme  II. PAST MEDICAL HISTORY  Herpes Zoster Yes / No If yes, date of incident Hypertension Yes / No If yes, state deficiency? Yes / No If yes, state deficiency Hypertension Yes / No If yes, state deficiency Current treatment Hypertension Yes / No If yes, when detected Current treatment Ashmary Fyes/No If yes, when detected Current treatment Ashmary Fyes/No If yes, when detected Current treatment Allergies Yes / No If yes, date of last episode If yes, type of fits Allergies Yes / No If yes, date of last reaction Cause of reaction Any Deformity? Yes / No If yes, which part of the body Date of surgery Date of su	[Please Write in Block Letters] I. PERSONAL INFORMATION						
Date of Birth   Gender   Programme	Full Name	F1fSU:	Midaie:	Last:	Marital Status		
II. PAST MEDICAL HISTORY		<u> </u>	Gender				
Any loss of consciousness? Yes / No  If yes, dates of incident							
If yes, dates of incident	(I) NERVOUS SYS	STEM		Herpes Zo	Herpes Zoster Yes / No		
Hypertension Yes / No   If yes, state deficiency? Yes / No   If yes, state deficiency	Any loss of consciousness? Yes / No			If yes, date	If yes, date of illness		
Any neurological deficiency? Yes / No  If yes, state deficiency  When acquired  Current treatment  Asthma Yes / No  If yes, when detected  Current treatment  Asthma Yes / No  If yes, when detected  Current treatment  Asthma Yes / No  If yes, when detected  Current treatment  Allergies Yes / No  Date of last episode  Current treatment  Cause of reaction  (I) Musculo-Skeletal System  Any Deformity? Yes / No  If yes, type of surgery  When acquired  Use of accessories or aids  Ill yes, what disease?  Current treatment  Current treatment  If yes, when detected  Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  If yes, when detected  Current betatus  If yes, when detected is treation  Current betatus  If yes, when detected is treation  Current greatment  III. DECLARATION	If yes, dates of incident			Part of bod	Part of body affected		
If yes, state deficiency Current treatment	Current treatment			Hypertens	Hypertension Yes / No		
Asthma Yes / No  Current treatment	Any neurological deficiency? Yes / No			If yes, whe	If yes, when detected		
Current treatment	If yes, state deficiency			Current tre	Current treatment		
Any fits? Yes/No  If yes, type of fits	When acquired			Asthma Ye	Asthma Yes / No		
Allergies Yes / No Date of last episode	Current treatment			If yes, whe	If yes, when detected		
Date of last episode	Any fits? Yes/No			Current tre	Current treatment		
Cause of reaction	If yes, type of fits			Allergies \	Allergies Yes / No		
Major Surgeries Yes / No   If yes, type of surgery   Date of surgery   Date of surgery   Outcome of surgery   Outcome of surgery   Any Heart Disease Yes / No   If yes, what disease?   Any Heart Disease Yes / No   If yes, what disease?   Ourrent Treatment   Any Dietary Restrictions Yes / No   If yes, when detected   Any Dietary Restriction   Outcome of surgery   Any Heart Disease Yes / No   If yes, what disease?   Outcome of surgery   Any Heart Disease Yes / No   If yes, what disease?   Outrent Treatment   Any Dietary Restrictions Yes / No   Outcome of surgery   Outcom	Date of last episode			If yes, date	If yes, date of last reaction		
Any Deformity? Yes / No  If yes, type of surgery	Current treatme	nt		Cause of re	Cause of reaction		
Date of surgery	(II) MUSCULO-SKELETAL SYSTEM			Major Sur	Major Surgeries Yes / No		
When acquired Outcome of surgery Any Heart Disease Yes / No  (III) OTHER CHRONIC CONDITIONS	Any Deformity? Yes / No			If yes, type	If yes, type of surgery		
Use of accessories or aids	If yes, which part of the body			Date of sur	Date of surgery		
Current Treatment	When acquired			Outcome of	Outcome of surgery		
Diabetes Mellitus Yes / No  If yes, when detected Any Dietary Restrictions Yes / No  Current Status If yes, when detected Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	Use of accessories or aids			Any Heart			
Any Dietary Restrictions Yes / No  Current Status   If yes, state restriction    Tuberculosis Yes / No  If yes, when detected   Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	(III) OTHER CHRONIC CONDITIONS			If yes, wha	If yes, what disease?		
Current Status   If yes, state restriction   Tuberculosis Yes / No  If yes, when detected   Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	Diabetes Mellitus Yes / No			Current Tre	Current Treatment		
Tuberculosis Yes / No  If yes, when detected Current status Cured / On going treatment  Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	If yes, when detected			Any Dietai	Any Dietary Restrictions Yes / No		
If yes, when detected Please Note: The applicant is responsible for maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	Current Status			If yes, state	e restriction		
Current status Cured / On going treatment maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	Tuberculosis Y	'es / No					
Current status Cured / On going treatment maintaining any dietary restrictions.  III. DECLARATION  I declare that all the information provided herein is true to the best of my knowledge.	If yes, when detected			Please No	te. The annlicant is responsible for		
I declare that all the information provided herein is true to the best of my knowledge.	Current status Cured / On going treatment						
	III. DECLARATION						
Signature Date	I declare that all the information provided herein is true to the best of my knowledge.						
		Signature			Date		

#### SECTION B (TO BE COMPLETED BY A REGISTERED MEDICAL OFFICER)

	VARIOUS TESTS				
(I) GENERAL APPEARANCE	(II) CARDIO-RESPIRATORY SYSTEM				
Height Weight	(CHEST X-RAY FILM & REPORT ARE NEEDED)				
Blood PressurePulse Rate	Lung Fields Breast Lumps				
Lymphnode Palpable	Heart Size Heart Sounds				
Skin Appearance	(III) ABDOMINAL EXAMINATION				
Throat Tonsils	(ABDOMINAL U.S.S. REPORT IS NEEDED. IF MASS DETECTED				
Teeth Dentition Carious	FILM IS NEEDED)				
	Contour: Sunken / Normal / Distended				
EARS:	Skin Scar				
Rt Hearing Drum Membrane	Umbilicus Hernia				
Lt HearingDrum Membrane	(IV) MUSCULO SKELETAL SYSTEM				
EYES:	Any Deformation? Yes / No				
Rt VA Squint	If yes which part of the body				
Lt VA Squint	Type of deformity				
V. LABORATORY INVESTIGATIONS					
(I) BIOCHEMICAL	(III) HEMATOLOGY				
Fasting Blood Sugar	(CULTA COUNTER)				
Serum Creatinine	Haemoglobin				
Serum Aspantate T.	White Cells Count				
Serum Alanine T.	(IV) PARASITOLOGY				
Blood Urea	Stool Routine Examination				
Uric Acid	Treatment				
(II) IMMUNOLOGY	Urinalysis & Sedment Microscopy				
VDRL Reaction if +ve treatment	Treatment				
Widal Reaction if +ve treatment	Blood Smear for Protozoa, Hemoflagellets & Spirachaetae				
Contact with Human Immunodeficiency Virus					
Sero Conversion (Optional)	Treatment				
VI. OTHER OBSERVATIONS					
Any other observations whether irritable or aggre	essive:				
VII. DECLARATION					
l Dr of	has examined the named candidate				
	and conclude that the candidate is / is not suitable to attend				
a one / two / three year programme at Tuma	aini University, Stefano Moshi Memorial University College				
Signature with Official Stamp	Date				