

BAHAGIAN B - Sila tandakan (✓) dalam kotak yang berkenaan
(**PART B** - Please tick (✓) in the relevant box.)

Pengisytiharan tahap kesihatan diri sendiri dan keluarga. Sila maklumkan dengan jelas jika anda atau ahli keluarga anda menghadapi penyakit-penyakit berikut. Ahli keluarga adalah ibu, bapa dan adik beradik.

(Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses. Immediate family refers to father, mother, brothers / sisters.)

MASALAH PERUBATAN (MEDICAL PROBLEMS)	SENDIRI (SELF)		KELUARGA (FAMILY)		Jika "Ya" sila nyatakan (If "Yes" please state)
	Ya (Yes)	Tidak (No)	Ya (Yes)	Tidak (No)	
1. Kecacatan kekal atau penyakit diwarisi / <i>Congenital or inherited disorder</i>					
2. Alahan / <i>Allergy</i>					
3. Penyakit mental / <i>Mental illness</i>					
4. Sawan, angin ahmar, penyakit saraf yang lain / <i>Fits, stroke, other neurological disease</i>					
5. Kencing manis / <i>Diabetes Mellitus</i>					
6. Darah tinggi / <i>Hypertension</i>					
7. Penyakit jantung atau kardiovaskular / <i>Heart or vascular disease</i>					
8. Lelah / <i>Asthma</i>					
9. Penyakit tiroid / <i>Thyroid disease</i>					
10. Penyakit buah pinggang / <i>Kidney disease</i>					
11. Kanser / <i>Cancer</i>					
12. Batuk kering / <i>Tuberculosis</i>					
13. Ketagihan dadah / <i>Drug addiction</i>					
14. AIDS, HIV					
15. Sejarah pembedahan / <i>History of surgery</i>					
16. Hepatitis B/C					
17. Penyakit lain / <i>Other illnesses</i>					

Perubatan semasa (jangkamas panjang / *Current medication (Long term)*)

1. _____ 3. _____
2. _____ 4. _____

.....SEJARAH IMUNISASI – jika berkenaan (<i>IMMUNIZATION HISTORY - where applicable</i>)	TARIKH IMUNISASI (<i>DATE IMMUNIZED</i>)				
1. BCG					
2. Hepatitis B					
3. Rubella					
4. Yellow Fever					
5. Meningococcal					
6. Typhoid					
7. Influenza					
8. Lain-lain / Others					

*Sekiranya perlu, pelajar adalah dinasihatkan untuk mendapatkan pelalian yang berkaitan dengan nasihat pegawai perubatan.
(*Students are hereby advised to consult medical officer if vaccination is needed.*)

Saya dengan ini mengesahkan bahawa maklumat di atas adalah benar. Saya sedia maklum bahawa permohonan saya akan ditolak sekiranya maklumat yang diberikan adalah tidak benar. Saya dengan ini memberi keizinan agar laporan perubatan ini diserahkan kepada pihak universiti.

(*I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given. I hereby give my consent for this medical report to be submitted to the university.*)

.....
Tarikh / Date

Tandatangan calon /
Signature of candidate

Name :
 IC No :

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
BMI : _____ kg/m ²	
VISION TEST : Unaided : (R) _____ (L) _____	COLOUR VISION TEST :
Aided : (R) _____ (L) _____	NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

Name :
 IC No :

SECTION 3 - INVESTIGATIONS

Part 1: (FOR LOCAL & INTERNATIONAL STUDENT)

URINE TEST		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		

Part 2: (FOR INTERNATIONAL STUDENT ONLY)

URINE FOR DRUGS		
ITEM	DATE TAKEN	RESULT
a. MORPHINE		
b. CANNABIS		
c. AMPHETAMINES TYPE STIMULANT		

BLOOD TEST		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS Bs ANTIBODY		
c. HEPATITIS C		
d. VDRL / TPHA		
e. HIV		
f. MALARIAL PARASITE		
g. RUBELLA SEROLOGY		

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

Name :
IC No :

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

I hereby certify that I have examined _____
with ID No. / Passport No. _____ on this date _____
and found him/her:

IN GOOD HEALTH

HAS MEDICAL PROBLEM (Please State)

IS UNDERGOING TREATMENT FOR: (Please State)

Date _____

Signature of Doctor : _____
Name of Doctor : _____
Qualification & : _____
Official stamp of Clinic

Remarks by University Official: