ABUBAKAR TAFAWA BALEWA UNIVERSITY BAUCHI

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

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

MEDICAL EXAMINATION OF PROSPECTIVE STUDENT

FOR OFFICE USE:----------

Students are requested to complete **Part I** of this form and then pass it on to a qualified Medical practitioner who will carry out Medical Examination and complete **Part II** of the Form, Thereafter, the form should be returned to the **Registrar Abubakar Tafawa Balewa University, Bauchi**,

The information supplied will be treated as confidential.

PART I (To completed by the Student)

i) Full Name:----------
ii) Reg. No.: ----------
iii) Department of: ----------
iv) School of: ----------
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.----------

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Personal Health History (Just thick)

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

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

Have you suffered from or do you suffer 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 on any of the followings). If yes, please indicate date.

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 III (To be completed by the Doctor)

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

Weight:----------Kilograms

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

URINE ANALYSIS

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

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

BLOOD

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

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

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

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

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

Any other comments by the Medical Practitioner:----------

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

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

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

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