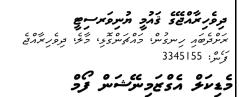


The Maldives National University

Rahdhebai hin'gun, Machchangolhi, Male', Maldives. Phone 3345155

Medical Examination Form



- 1. Please read the instructions carefully before filling in the form.
- Please fill in the form in English language.
- Please write in CAPITAL LETTERS.
- 4. This form has 4 sections. Section 1 (Part A and B) is to be filled by the candidates. Section 2, 3 and 4 is to be filled by the examining doctor
- 5. Please complete all the tests required in this form.
- 6. The university accepts medical examinations done within 60 days before registration.
- 7. Chest x-ray done within 6 months prior to registration can be accepted.
- 8. The university has the right to repeat full medical check-up or any specific laboratory tests if there is
- 9. The university has the right to reject any application:
 - (a) Based on the results of the health examination
 - (b) if the applicant has given false information in the health examination report or any supporting

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate) (PART A)

Ful	l Na	me	(as	in 1	Vati	ona	l ID))													
Pas	assport No. (for international students only) MNU Student ID																				
Na	tiona	ality										1	Со	ntac	t N	umb	er				
Aca	ader	mic	Yea	ar	Υ		Ter	Age	e 		Se: Ma Fer	:			Sin			atus			
Ne	Next of Kin's Address																				
Ne	Next of Kin's Contact Number																				

SECTION 1

(PART B) - Please tick (\checkmark) in the relevant box

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

No	MEDICAL PROBLEMS	SELF		IMMEDEATE FAMILY		If "Yes" please state.
		Yes	No	Yes	No	
1	Congenital or inherited disorder					
2	Allergy					
3	Mental illness					
4	Fits, stroke, other neurological disease					
5	Diabetes Mellitus					
6	Hypertension					
7	Heart or vascular disease					
8	Asthma					
9	Thyroid disease					
10	Kidney disease					
11	Cancer					
12	Tuberculosis					
13	Drug addiction					
14	AIDS / HIV					
15	History of surgery					
16	Other illnesses					
17	Smoker					
18	Hepatitis B / Hepatitis C					

No	IMMUNIZATION HISTROY (WHERE APPLICABLE)	DATE OF IMMUNIZATION
1	Chicken pox	
2	BCG	
3	Meningitis (Quadrivalent)	
4	Hepatitis B	
5	Others:	

3	Meningitis (Quadrivalent)							
4	Hepatitis B							
5	Others:							
Cu	rrent medication (Long term)							
	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.							
	Date	Signature of candidate						

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT							
Height (m):			Blood pressure (mmHg):				
Weight (kg):			Puluse rate: (/ min)				
Vision Test :	Unaided: (R)	(L)	Colour Vision Test :				
	Aided : (R)	(L)	Normal / Abnormal				

2.	2. GENERAL EXAMINATION								
	ITEM	YES	NO	COMMENT					
a.	Deformities								
b.	Pallor								
c.	Cyanosis								
d.	Jaundice								
e.	Oedema								
f.	Skin Diseases								

3.	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								

SECTION 3 - INVESTIGATIONS

UF	URINE TEST							
	ITEM	DATE TAKEN	RESULT					
a.	Albumin							
b.	Sugar							
c.	Microsopic							

BLOOD TEST							
ITEM		DATE TAKEN	RESULT				
a. Hepatitis bs Antigen	l						
b. Hepatitis B Antibody	′						
c. Hepatitis C							
d. HIV Ag/Ab							
e. VDRL/TPHA							

CHEST X-RAY IN	IFORMATION	
Chet X-ray No.		
Date taken		
Place Taken		
Report		

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tic	k (\checkmark) in the relevant box		
Mr / Ms	at I have on this date	ID No	·
	The above named is in good health	I	
	The aboved named has the following		
	The above named is undergoing tre	eatment for (please state)	
Date:		Signature of Doctor	
Date		Signature of Doctor Name of Doctor	: :
		Qualification	:
		Hospital/Clinic Dr.'s Registration Number	:
		Official stamp	:
Remarks	s By University Official :		