



UNITED STATES INTERNATIONAL UNIVERSITY

"Education to take you places"

HEALTH RECORD FORM

1. PERSONAL HISTORY

Surname: Other names:
Date of birth: Place of birth:
Next Of kin: Relationship:
Address: Tel. No.....

2. SOCIAL HISTORY (Please indicate 'X' where appropriate)

Alcohol: YES..... NO..... HOW OFTEN (if yes).....
Tobacco: YES.....NO..... HOW OFTEN (if yes).....
Regular doctor's medication: YES.....NO.....Which one.....

History of mental illness: NO.....YESGive details Below.....

Have you been suspended from school? NO..... YES give details.....

Do you suffer from any chronic illnesses? NO..... YES.....If yes, which one:
() Diabetes, () Hypertension, () Tuberculosis, () Hepatitis, () sickle cell disease, () leukemia

History of hospitalization? No.....Yes.....for how long

Have you had any of these symptoms for more than one week?
() Fever, () Cold Chills, () Weight Loss, () Diarrhoea, () vomiting.

Do you suffer from any allergies? No () Yes () if yes, which ones.....
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3. FAMILY HISTORY

Do any of your relatives suffer from?

() high Blood Pressure () diabetes, () Heart Disease, () Allergies, () Mental Illnesses, () Epilepsy, Other, Please specify.....

4. GENERAL EXAMINATION

General appearance: Weight.....

Height..... Respiratory System: Inspiration.....

Expiration.....

Cardiovascular System: Pulse...../mm B/P mmHg. Heart Sounds.....

Genito- Urinary.....

Ears/ Nose/throat.....

Skin.....Sight.....

Sight refraction: R/E.....L/E.....

Comments.....
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5. LABORATORY EXAMINATION (Please attach lab. Reports)

Heamogram E.S.R V.D.R.L Blood group

Chest X-ray P/A (*let your doctor decide if it's necessary*) attach only radiologist report.

Urinalysis..... Mantoux test (PPC).....

6. FOR DOCTORS USE ONLY (Official Stamp should be included)

Doctor's Name..... Signature.....

Qualification.....Date.....

7. PERSONAL DECLARATION

I hereby consent to offer this information to any medical authority as deemed necessary to effect quick treatment.

Student's

Name:.....Signature:.....Date:.....