

## STUDENT ENTRANCE MEDICAL EXAMINATION FORM

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

SECTION A (TO BE COMPLETED BY THE APPLICANT)			
<b>[Please Write in Block Letters] I. PERSONAL INFORMATION</b>			
Full Name	First:	Middle:	Last:
Date of Birth	Sex:	Marital Status:	
Academic Programme:			
II. PAST MEDICAL HISTORY			
<b>(I) NERVOUS SYSTEM</b> <b>Any loss of consciousness? Yes / No</b> If yes, dates of incident _____ Current treatment _____ <b>Any neurological deficiency? Yes / No</b> If yes, state deficiency _____ When acquired _____ Current treatment _____ <b>Any fits? Yes/No</b> If yes, type of fits _____ Date of last episode _____ Current treatment _____		<b>Herpes Zoster Yes / No</b> If yes, date of illness _____ Part of body affected _____ <b>Hypertension Yes / No</b> If yes, when detected _____ Current treatment _____ <b>Asthma Yes / No</b> If yes, when detected _____ Current treatment _____ <b>Allergies Yes / No</b> If yes, date of last reaction _____ Cause of reaction _____	
<b>(II) MUSCULO-SKELETAL SYSTEM</b> <b>Any Deformity? Yes / No</b> If yes, which part of the body _____ When acquired _____ Use of accessories or aids _____		<b>Major Surgeries Yes / No</b> If yes, type of surgery _____ Date of surgery _____ Outcome of surgery _____ <b>Any Heart Disease Yes / No</b> If yes, what disease? _____ Current Treatment _____ <b>Any Dietary Restrictions Yes / No</b> If yes, state restriction _____	
<b>(III) OTHER CHRONIC CONDITIONS</b> <b>Diabetes Mellitus Yes / No</b> If yes, when detected _____ Current Status _____ <b>Tuberculosis Yes / No</b> If yes, when detected _____ Current status Cured / Ongoing treatment		<b>Please Note: The applicant is responsible for maintaining any dietary restrictions.</b>	
III. DECLARATION			
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 OR DOCTOR)	
IV. VARIOUS TESTS	
<b>(I) GENERAL APPEARANCE</b> Height _____ Weight _____	<b>(II) CARDIO-RESPIRATORY SYSTEM</b> <b>(CHEST X-RAY FILM &amp; REPORT ARE NEEDED)</b>

Blood Pressure _____ Pulse Rate _____ Lymphnode Palpable _____ Skin Appearance _____ Throat Tonsils _____ Teeth Dentition _____ Carious _____ EARS: Rt Hearing _____ Drum Membrane _____ Lt Hearing _____ Drum Membrane _____ EYES: Rt VA _____ Squint _____ Lt VA _____ Squint _____	Lung Fields _____ Breast Lumps _____ Heart Size _____ Heart Sounds _____ <b>(III) ABDOMINAL EXAMINATION</b> <b>(ABDOMINAL U.S.S. REPORT IS NEEDED. IF MASS DETECTED FILM IS NEEDED)</b> Contour: Sunken / Normal / Distended Skin Scar _____ Umbilicus _____ Hernia _____ <b>(IV) MUSCULO SKELETAL SYSTEM</b> Any Deformation? Yes / No If yes which part of the body _____ Type of deformity _____
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**V. LABORATORY INVESTIGATIONS**

<b>(I) BIOCHEMICAL</b> Fasting Blood Sugar _____ Serum Creatinine _____ Serum Aspartate T. _____ Serum Alanine T. _____ Blood Urea _____ Uric Acid _____ <b>(II) IMMUNOLOGY</b> VDRL Reaction if +ve treatment _____ Widal Reaction if +ve treatment _____ Contact with Human Immunodeficiency Virus Sero conversion (Optional) _____	<b>(III) HEMATOLOGY</b> <b>(CULTA COUNTER)</b> Haemoglobin _____ White Cells Count _____ <b>(IV) PARASITOLOGY</b> Stool Routine Examination _____ Treatment _____ Urinalysis & Sediment Microscopy _____ Treatment _____ Blood Smear for Protozoa, Hemoflagellates & Spirochaetae _____ Treatment _____
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**VI. OTHER OBSERVATIONS**

Any other observations whether irritable or aggressive:

**VII. DECLARATION**

I Dr. \_\_\_\_\_ of \_\_\_\_\_ has examined the named and consider that he/she is physically and mentally fit\* / not fit\* to be admitted to the Institute of Tax Administration for Higher studies.

Signature with Official Stamp \_\_\_\_\_ Date \_\_\_\_\_

Note: \* delete whichever is not applicable