

BAHAGIAN 2 – Sila tandakan (√) di kotak berkenaan.*PART 2 – Please tick (√) in the relevant box.*

Pengakuan penyakit diri dan keluarga. Jelaskan jika anda mengidap penyakit berikut atau penyakit lain yang serius.

Declaration of self and family illness. Explain in full if you or your family has any of the following or other serious illnesses.

Masalah / <i>Problems</i>	Sendiri / <i>Self</i>		Keluarga / <i>Family</i>		Jika “Ya” sila nyatakan / <i>If “Yes” please state.</i>
	Ya / <i>Yes</i>	Tidak / <i>No</i>	Ya / <i>Yes</i>	Tidak / <i>No</i>	
Penyakit sejak lahir atau baka / <i>Congenital or inherited disorder</i>					
Alahan / <i>Allergy</i>					
Sakit jiwa / <i>Mental illness</i>					
Sawan, angin ahmal, penyakit saraf / <i>Fits, stroke, other neurological</i>					
Kencing manis / <i>Diabetes</i>					
Darah tinggi / <i>Hypertension</i>					
Jantung atau salur darah / <i>Heart or vascular disease</i>					
Asma / <i>Asthma</i>					
Sakit buah pinggang / <i>Kidney disease</i>					
Barah / <i>Cancer</i>					
Batuk kering / <i>Tuberculosis</i>					
Ketagihan dadah / <i>Drug addiction</i>					
AIDS, HIV					
Sejarah pembedahan / <i>History of surgery</i>					
Penyakit serius lain / <i>Other serious illnesses</i>					

Sejarah imunisasi / *Immunization history*Tarikh imunisasi / *Date immunized*

a) Yellow fever

b) BCG

c) Typhoid

d) Meningitis (Quadrivalent)

e) Hepatitis B

Saya dengan ini mengaku bahawa keterangan yang diberi di atas adalah benar. / *I hereby certify that the information given above is true.*

Tarikh / *Date*-----
Tandatangan calon /
Signature of candidate

PART 3

TO FILLED BY EXAMINING DOCTOR

1. General examinations

a. Height

 cm b. Weight

 kg
 c. Pulse

 Per minute d. BP

 mmHg

a. Pallor <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> c. Oedema <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> e. Lymphnodes <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>													b. Cyanosis <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> d. Jaundice <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table> f. Skin <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>												

2. Eyes

	Right	<input type="text"/>	Left	<input type="text"/>	<i>Additional comments</i>
a. Unaided vision					_____
b. Aided vision	Right	<input type="text"/>	Left	<input type="text"/>	_____
c. Colour vision	Normal	<input type="text"/>	Abnormal	<input type="text"/>	_____
d. Funduscopy	Normal	<input type="text"/>	Abnormal	<input type="text"/>	_____

3. Ears Normal Abnormal _____

4. Oral cavity Normal Abnormal _____

5. Respiratory system

a. Examination	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>
b. Chest X-ray	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>

Date of X-ray

--	--	--	--	--	--

Place X-ray taken

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X-ray reference N^o

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6. Cardiovascular	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>
7. Abdomen and hernia orifices	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>
8. Nervous system and mental condition	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>
9. Musculoskeletal system	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>
10. Others	Normal	<input type="text"/>	Abnormal	<input type="text"/>	<input type="text"/>

PART 4 *

11. Urine
a. Sugar b. Albumin c. Microscopy _____
12. Drugs:
a. opiate b. cannabis _____
c. amphetamines d. methamphetamines _____
e. ketamin _____
13. Blood
a. Malarial parasite b. VDRL _____
c. Hepatitis B Ag d. Hepatitis B Ab _____
e. Hepatitis C f. HIV _____

*** Note: Malaysian students are only required to do 11a, 11b, 11c only.**

PART 5

Certification by doctor: Please tick (√) in the appropriate box

I hereby certify that I have on this date _____ examined _____
Identification card number / Passport number _____ and found:

- | | | |
|--------------------------|--|-------|
| <input type="checkbox"/> | The above named is in good health | |
| <input type="checkbox"/> | The above named has | _____ |
| <input type="checkbox"/> | The above named is undergoing treatment for: | _____ |

Date _____

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