UNIVERSITY OF ABUJA

(Office of the Vice Chancellor)

UNIVERSITY MEDICAL CENTRE

PROCEDURE FOR THE 2017/2018 ACADEMIC SESSION MEDICAL EXAMINATION AND CLINIC REGISTRATION FOR NEWLY ADMITTED STUDENTS.

DATE: Monday 5th FEBRUARY – Friday 16th MARCH 2018 (6 WEEKS)

VENUE: 1**. Main Campus Clinic** (Faculty of Arts, Management Sciences, Engineering, Agriculture, Veterinary Medicine, College of Health Science. Departments of Biology, Microbiology, Mathematics, Statistics, Computer Science and Physics).

2. **Mini Campus Clinic** (Faculty of Social Sciences, Education, Institute of Education, Department of Chemistry).

TIME: 9:00am – 2:00 pm Daily.

PROCEDURE

1. Download student medical history and screening form from the university portal
2. Fill the part 1 of the form
3. Take the filled form to a recognized government hospital where a qualified medical doctor will complete part II of the form
4. Bring the filled and duly signed form to the University Medical Centre.
5. Present evidence of payment of school fees to the finance officer
6. Go to the medical records office with
   i. Three (3) passport size photographs
   ii. Chest X-ray film and report
   iii. Results of laboratory investigation
   iv. Filled and signed medical history and screening form
7. Proceed to the consulting room
8. collect your clinic hand card from the medical records office

NOTE: This card is **non – reissuable;** which means that **you use only one card during your stay in the University.** Bring it **always to the clinic** any time you feel sick or need to consult a Doctor. You are advised to keep it safe.

Thank you.

Acting Director, UMC

UNIVERSITY OF ABUJA

STUDENT MEDICAL HISTORY AND SCREENING FORM

PASSPORT SIZE PHOTOGRAPHY

Undergraduate and postgraduate students are requested to complete Part I of this form. Part II should be completed with the help of a qualified medical doctor from a recognized government hospital. The form should be returned to the Director, University Medical Centre after completion.

The information will be treated in strict confidence.

The purpose is to screen for possible health problems and give guidance to encourage excellent health.

PART I (To be filled by the student)

General Information

Surname: ..... Other names .....

Sex ..... Date of Birth.....

Address: .....

.....

Contact Phone Number ..... Marital status .....

Nationality: ..... State of Origin .....

Local Government Area .....

Faculty ..... Department .....

Past Medical History

Answer YES or NO and comment below.

Have you ever had or do you have any of the following health problems?

- **Cardiac**
  - High Blood Pressure
  - Heart Attack
  - palpitation
- **Lung**
  - Sleep apnea
  - Orthopnea
  - Asthma
  - Chronic obstructive pulmonary disease
  - Tuberculosis
  - Seasonal allergies

  Other: .....
- **Hemoglobinopathies**
- **G I**
  - Jaundice
  - Liver disease
  - Gall bladder disease
  - Gastritis/Ulcer disease
  - Acid reflux
  - Haemorrhoids
  - Other

    .....
- **Kidney**
  - Kidney infection
  - Bladder infection
  - Kidney stones

- Sickle cell disease
- Thalassemias

Other: …….

- **Substance abuse**
  - Alcohol
  - Marijuana
  - Other drugs
- **Diabetes**
- **Thyroid disorder**
- **Hepatitis**
- **Dental disease**
- **Glaucoma**
- **High Cholesterol**
- **Serious trauma**
- **Neuro**
  - Migraine
  - Stroke
  - Seizure

  Other
  ……..
- **Psychiatry**
  - Depression
  - Anxiety
  - Bipolar
  - Eating disorder
- **Environmental allergies**
- **Bleeding tendency**

Comments if the answer to any of the above is YES, please give details with dates.

……

……

- **Surgeries**

Type of surgery and specific date:……

……

- **Hospitalizations**

Name of Hospital, dates and reasons for hospitalization.

……

……

- **Medications**

Are you on any prescription medications YES/NO

List the drugs you are currently taking …… ……

……

- **Allergies**

List any drug that you have reaction to:……

……

- **Family History**

Does any member of your family (i.e. parents, grandparents, siblings) have these illnesses?

- High blood pressure

- Diabetes
- Mental illness
- Heart disease
- Stroke
- Migraines/headaches

■ **Immunization History**

- BCG — Date ……..
- CSM — Date ……..
- Tetanus — Date ……..
- Others — Date ……..

■ **Gynecologic History (females only)**

Do you have a period every month, YES/NO

Number of days of flow ……

Menstrual camps: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Date…… Student signature ……

PART II

(To be completed by a qualified medical doctor from a recognized government hospital)

Height …… meters. Weight ……. Kg

Abdominal girth ……cm

Visual acuity	R	L
Without glasses		
With glasses		

Hearing:	R	L
Eyes:		
Ears:		
Pharynx:		
Teeth:		
Lymphatic glands:		

CNS:

CVS: Pulse rate
Blood pressure
Heart sound

Respiratory system:

Abdomen:

Laboratory investigations (attach results)

S/N	TEST	REMARKS
1.	urinalysis	
2.	Stool Microscopy	
3.	PCV	
4.	Blood Group	
5.	Genotype	
6.	Mantoux test	

Chest X-ray (attach radiologist report

Name of Hospital: ……

Film No.

Radiologist report ……

……

Medical Doctor's Remarks: I have examined ……..

and found him/her to be physically and mentally fit for studies in your institution.

Name of Medical Doctor: ……..

Folio no.; MDCN/R/…….

Hospital address (not P.O. Box) ……

……

Doctor's signature and date……

(Hospital stamp)