LINCOLN COLLEGE

MEDICAL FORM

DIRECTIONS: PLEASE READ AND ANSWER ALL QUESTIONS **CAREFULLY** AND **COMPLETELY**.

NOTE: FULL DISCLOSURE OF ALL SIGNIFICANT MEDICAL CONDITIONS IS REQUIRED.

DATE: _____

1. **PERSONAL INFORMATION (to be filled out by student):**

_____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL(S)

_____/_____/_____ _____ _____ _____
DOB (dd/mm/yy) AGE GENDER BLOOD GROUP

_____
HOME ADDRESS

_____
HOME ADDRESS

(_____)_____-_____ (_____)_____-_____ _____
HOME PHONE # CELL PHONE # EMAIL ADDRESS

2. **CONTACT PERSONS IN CASE OF EMERGENCY: (Next of Kin)**

Person 1

LAST NAME _____ FIRST NAME _____

RELATIONSHIP_____

_____
HOME ADDRESS

_____
HOME ADDRESS

(_____)_____-_____ (_____)_____-_____ _____
HOME PHONE # CELL PHONE # EMAIL ADDRESS

PERSON 2

LAST NAME _____ FIRST NAME _____

RELATIONSHIP_____

_____
HOME ADDRESS

_____

HOME ADDRESS

(_____)_____-_____ (_____)_____-_____ _____

HOME PHONE # CELL PHONE # EMAIL ADDRESS

3. **FAMILY PHYSICIAN'S NAME** _____CONTACT NUMBER _____
4. **FAMILY HISTORY**

	YES	**NO**
Is there a family history of?		
Diabetes	☐	☐
Hypertension	☐	☐
Asthma	☐	☐
Mental Illness	☐	☐

If yes, Relationship: _____

5. **PATIENTS' MEDICAL HISTORY**

Please indicate if you suffer from any of these chronic illnesses:

	YES	**NO**
Asthma	☐	☐
Epilepsy	☐	☐
Diabetes	☐	☐
Hypertension	☐	☐
Migraine	☐	☐
Allergies	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Sickle Cell Disease	☐	☐
Mental illness (including Depression)	☐	☐
Haemophilia	☐	☐
Chronic Anaemia	☐	☐

Any other Illnesses:

_____

If yes, are you being treated? **YES** ☐ ☐ **NO**

6. **PAST GYNAECOLOGICAL HISTORY (if applicable):**

Menarche _____ Last Menstrual Period _____Duration of Period _____

Frequency_____Menorrhoea_____dysmenorrhoea_____

7. **DRUG HISTORY:**

_____

_____

8. **ALLERGY:** DRUG _____
   Food _____
   Others _____

9. **IMMUNIZATION STATUS: (Please indicate date of last vaccine)**
   BCG _____ DPT _____ Polio_____
   Hepatitis B _____ MMR _____ Yellow Fever _____
   Any Other Vaccines (please specify) _____

10. **IMPAIRMENT OR DISABILITY**

Do you have any impairment or disability? ☐ YES ☐ NO

If YES, please explain

_____

I confirm that to the best of my knowledge the information provided above is accurate.

_____ _____

STUDENT SIGNATURE DATE

Physical Examination (to be filled out by a doctor)

Please indicate whether systems are **Normal (N)** or **Abnormal (Ab).** If abnormal, please state abnormalities.

1. **Vitals:** respiration rate: _____ temperature: _____ blood pressure: _____ pulse rate _____
   Height: ____ft ____in / _____ meters Weight: _____lbs / _____ kg
2. **Central Nervous System** (coordination, reflexes) _____
3. **Mucous membrane:** _____
4. **Sclera:**_____
5. **Skin:**_____
6. **Respiratory System:** _____

7. **Cardiovascular System** (pulses, heart sounds, murmurs):
   _____
   _____
8. **Abdomen** (organomegaly, hernias, genitals):_____
9. Musculo-Skeletal _____

Feet: Arch ☐ Normal ☐ Flat ☐

10. **VISION:** left eye _____ right eye ____
11. **EARS:** left ear _____ right ear _____
12. **DENTAL:** presence of dental caries Yes _____ No _____ [Last dental visit – under personal section]
13. **BLOOD STUDIES:**

Hb (g/dl) _____ WBC (×10°) _____ Platelets (×109) _____ Sickle _____

HIV _____ VDRL _____ R&G _____ BUN _____

Hepatitis A _____ Hepatitis B _____

14. **MANTOUX TEST:** (If Necessary) Positive _____ Negative _____
15. **URINE ANALYSIS:** _____
16. Chest X-Ray _____

COMMENTS:_____
_____

I certify that I made this examination at _____☐ a.m. ☐ p.m. on the day of _____, 20_____.

PHYSICIAN'S SIGNATURE _____

PHYSICIAN'S FULL NAME (PLEASE PRINT) _____

PHYSICIAN'S ADDRESS _____

PHYSICIAN'S STAMP