NANYANG TECHNOLOGICAL UNIVERSITY SINGAPORE

MC1 – NTU Health Screening Form (Part I)
PART I: CONFIDENTIAL MEDICAL HISTORY (To be completed by the student)

PERSONAL PARTICULARS

Full Name (Block Letter): _____ Sex: _____

Application No: _____ NRIC No./Passport No.: _____ Date of Birth: _____

Citizenship: _____ Programme of Study: _____ Mobile No.: _____

PERSONAL HISTORY	NO	YES	If yes, give details & dates
1. **NERVOUS SYSTEM/PSYCHIATRY** Frequent headaches, migraine, giddiness, fainting spells, epilepsy (fits), multiple sclerosis, nervous breakdown, anxiety disorder, depression, phobias, substance dependency, eating disorder, treated by psychiatrist or seen a counsellor before.			
2. **EYE, EAR, NOSE, THROAT** History of seeing black spots, bright lights, blur vision, hearing problems, ear infection, hearing loud noises (tinnitus), constant running nose, sneezing, blocked nose, nose bleeding.			
3. **RESPIRATORY SYSTEM** Asthma, frequent cough, tuberculosis, shortness of breath on and off.			
4. **CARDIOVASCULAR SYSTEM** Chest pain, palpitations, high blood pressure, heart murmur.			
5. **GASTROINTESTINAL SYSTEM** Gastric problem, frequent diarrhoea, constipation problem, stomach ulcer, abdominal pain on and off, bloatedness, piles (haemorrhoids).			
6. **GENITAL-URINARY SYSTEM** Sugar, protein or blood in urine, past urinary tract infection, kidney problem, testicular lumps (males only), hernia, sexually-transmitted infections.			
7. **ENDOCRINE SYSTEM** Thyroid problem, diabetes			
8. **MUSCULO-SKELETAL SYSTEM** Frequent backache, knee pain on and off, frequent ankle sprains, neck problem, shoulder problem, gout, previous fracture.			
9. **SKIN** Eczema, urticaria, fungal infection, psoriasis			
10. Any serious injuries, hospitalisation, operation			
11. Are you a Hepatitis B carrier?			
12. Any disability, impairment or special needs or illness/condition not mentioned above?			
13. **FOR FEMALES ONLY** History of breast lump, menses problem eg. irregular menses, menses pain, etc			

FAMILY HISTORY	NO	YES	If yes, give details & dates
1. Hypertension			
2. Heart Disease			
3. Stroke			
4. Diabetes			
5. Tuberculosis			
6. Mental Disorder			
7. Others			

SOCIAL HISTORY	NO	YES	If yes, give details & dates
1. Cigarettes			No. of cigarettes/day: No. of years:
2. Alcohol			
DRUG HISTORY	**NO**	**YES**	**If yes, give details & dates**
1. Drugs taken presently			
2. Allergy			

Data Protection Information

Your health records are held in confidence by the Medical Centre at NTU. NTU will be informed of the results of your health examination. If necessary, this information may be used to make adjustments to your academic or campus experience, particularly if it is relevant to your educational needs or impacts the safety of those you interact with.

Declaration

I hereby declare that I have not withheld any relevant information or made any misleading statement. I consent to my information being held and processed by the Medical Centre at NTU as described in the 'Data Protection Information' above.

Student's Signature _____ Date _____

MC1 – NTU Medical Examination Form (Part II)

NANYANG TECHNOLOGICAL UNIVERSITY

PART II: REPORT OF MEDICAL EXAMINATION
(To be completed by a Registered Physician)

SIGNIFICANT MEDICAL HISTORY (including psychiatric disorders):

PHYSICAL EXAMINATION

Height:_____m Weight:_____kg Vision: R 6/____ L 6/____ aided/unaided Colour Vision: normal/ partial red green deficency - wire test Pass/ Fail

Blood Pressure:_____ Pulse Rate: _____

Cardiovascular System: _____

Respiratory System: _____

Abdomen (Note presence of hernia): _____

Central Nervous System: _____

Musculoskeletal System: _____

Others: _____

INVESTIGATION

Urine Protein:_____ Sugar:_____ Others:_____

Chest X-ray report: Only required for students pursuing LKC Medicine programs, Chinese Medicine, Early Childhood, and for all International Students, which should be done within the last 3 months and film should be attached if done overseas.

OTHERS

Is patient now under treatment for any physical/emotional condition?

Do you have any recommendation regarding the care of this student?

Any drug allergy?

I certify that I have this day examined the abovenamed and the results of medical examination are as set forth. In my opinion, he/she is found to be in good health and free from any physical defect, organic or nervous ailments or after effects thereof which might render him/her unfit to pursue or complete his/her university programme of studies.

Physician's Signature | Name & Professional Qualifications | Date

Address: