STUDENT ENTRANCE MEDICAL EXAMINATION

Students are required to complete PART I of this form and leave PART II and PART III to be completed by a medical officer at the university Health Services U.I. The form should be returned to the Health Service.

for official use only
Clinic No:

PART I (to be filled by student - clarify unclear aspects with the Doctor)

Surname: ……. Other Names: ……....……...……

Age: ……Date of Birth: …*dd*…/…*mm*.../…*yyyy*… Sex: …….. Marital Status: …….....…….....

Nationality: ……... State: ……..... Faculty…..……Department: ……

Matric No: …… Hall Allocated: …… Tel No: ….……

Religion:……..……..…… Denomination: ……..……

For Emergencies:

Name of Next of Kin:..……..… Relationship to Next of Kin ……..

Address of Next of Kin: …… Telephone No of Next of Kin: .……..

Name of Contact Person in Ibadan or nearest to Ibadan:..……...…

Relationship to contact person: ……..… Telephone No of Contact Person: .……..

1. Have you ever been admitted in a hospital? Yes/No

If so, please state reason for admission, name of hospital and date: ……..

……...

2. History of previous Surgeries/Operations Yes/No

If yes, state surgery, year and hospital ……...

……...

3. Are you on any medication(s)? ..... If so, please state drug and dosage ……..……

4. Do you suffer from or have you suffered from any of the following

a.	Tuberculosis	Yes/No	f.	Diabetes	Yes/No
b.	Asthma	Yes/No	g.	Hypertension	Yes/No
c.	Peptic Ulcer Disease	Yes/No	h.	Seizures/Convulsions	Yes/No
d.	Sickle cell disease	Yes/No	i.	Mental illness	Yes/No
e.	Allergies	Yes/No	j.	Others: …….....	

5. If the answer to the above is yes, please give detail with dates:

……...……

6. Do you know your Genotype and Blood group Yes/No? If yes state your Genotype …… Blood Group ……..

8. If there are any other details of your medical history not covered, please state……...

…….....

9. Has anyone in your family suffered from Tuberculosis ……Seizures/Convulsions……..……

Hypertension …….. Diabetes ……Mental illness ……

10. Do you react to any drug(s) Yes/No if yes state the drugs(s) ……

11. Have you been immunized against any of the following:

Hepatitis B Yes/No Date …… Tetanus Yes/No Date ……

Yellow fever Yes/No Date …… C.S.M Yes/No Date ……

Others *(specify)*: …… Date ……

12. Do you currently use tobacco products such as cigarettes, snuff etc? Yes ☐ No ☐

13. If yes, on an average, how many cigarette sticks do you smoke per day? …… cigarettes/day

14. For how long have you used tobacco products e.g. cigarettes, snuff etc? ……

15. How old were you when you started using tobacco products? …….. years old

16. Do you have someone at home/school who smokes when you are present? Yes ☐ No ☐

17. Do you currently consume any alcohol? Yes ☐ No ☐ (*if no, go to 20*)

18. If yes, on an average, what is the frequency of consumption?

Equal to or more than 5 days per week ☐

1-4 days per week ☐
1-3 days a month ☐
Occasionally ☐

19. If yes, how many bottles/cans do you consume per day? .....
20. If no, have you ever consumed alcohol in any form? Yes ☐ No ☐
21. How old were you when you started consuming alcohol? ……..... years old.
22. During the past 1month, other than your regular activity, did you participate in any physical activities or exercises such as jogging, tennis, golf, gardening or walking for exercise? Yes ☐ No ☐
23. If yes, which exercise did you engage in……For how long (duration)? ..... ……
24. If yes, how often do you engage in this kind of exercise?
    a. Daily ☐ b. 1-3 times per week ☐ c. Once weekly ☐ d. 1-3 times per month ☐

Date:…… Signature:……

PART II

Height……(in meters only) Weight……kg

Visual acuity:

Without glasses R.6/ L.6/
With glasses R.6/ L.6/

Hearing

Left
Right

Eyes
Ears
Pharynx
Teeth
Lymphatic Glands

Circulatory System

Heart Rate
Rhythm
Sounds
Blood Pressure

Respiratory System

Lungs

G.I.T

Liver
Spleen
Hernia

C.N.S

Cognitive functions
Orientation
Memory
Intelligence
Pulpillary reflexes
Spinal reflexes

Any other observation? ……

PART III

URINE
Albumen
Sugar

CHEST X-Ray
Film No……
Date……..…
Result……..…

Date…… Name of Medical Officer…….....……

Signature…….....……

University Health Service

PSYCHOSOCIAL FORM

Section A

1. Family Status (Monogamous, Polygamous, Separated, Divorced/Single Parent)
2. No of full siblings: _____ No of half siblings: _____
3. Did you spend your childhood years with your parents? Yes ☐ No ☐
4. Relationship with No of Next Kin: _____
5. Name of Sponsor: _____
6. Occupation of Sponsor: _____
7. Average income of sponsor: _____
8. Hobbies: _____
9. Happiest Day (event): _____
10. What was your Reaction to the Event (happiest day): _____
11. Saddest Day (event): _____
12. What was your Reaction to the Event (saddest day): _____
13. No. of children in the Family: _____
14. Position in the Family: _____

Section B. Background Information on Psycho-social Issues

		5 SA	**4 A**	**3 ND**	**2 D**	**1 SD**
1.	I don't receive affection and support from my family members					
2.	I worry a lot about things happening in my family					
3.	I have a lot of issues that disturb my mind					
4.	I have to take stimulants, drugs, drinks to forget my sorrow					
5.	I feel sad most of the time					
6.	I don't feel excited about many things in life or life itself					
7.	I find it hard to have a sound sleep most of the time					
8.	I feel like having somebody with whom I can discuss my challenges					
9.	I prefer to keep to myself instead of having a friend or friends					

SA: Strongly Agree A: Agree ND: Not Decided D: Disagree SD: Strongly Disagree

Section C

Kindly tick as appropriate:

1. Past history of Assault:

	Yes	No
a. Physical	☐	☐
b. Sexual	☐	☐

2. Financial Support:

a. Good ☐

b. Average ☐

c. Poor

d. Estimated monthly financial support (N):……..

e. Are you satisfied with your monthly financial support Yes No

3. Your Relationship with Others

a. Poor ☐

b. Fair ☐

c. Good ☐

4. Medical challenge(s)

	Yes	No	
a. Physical	☐	☐	If yes, specify……
b. Emotional	☐	☐	If yes, specify……
c. Social	☐	☐	If yes, specify……

5. Are you confident of good performance in your academics? a. Unlikely ☐ b. Likely ☐ c. Most likely ☐

State reason for answer to 5. _____

_____

6. Can you afford to buy whatever you need conveniently? Yes No

☐ ☐

Section D

Information on Family Support within Ibadan Metropolis

In case you need to be treated, admitted in University health Service, Jaja Clinic or referred to any hospital from the University, please give names of two people that may be contacted in Ibadan for **prompt** response. (If you are not from Ibadan, you can mention names of members of your religious sects, association etc who can respond quickly)

1. Name:…… Phone No:……

2. Name:…… Phone No:……