MONASH University
MALAYSIA

MEDICAL EXAMINATION FORM (Medicine)

For Entry into Medicine Program at Monash University Malaysia

(The school will sent you the link to upload this form and the x-ray before the commencement date)

Applicant's Declaration *(to be completed by applicant)*

Monash Student ID : _____

Full Name : _____

NRIC No : _____ Age: _____ Gender: ❒ Female ❒ Male

Contact Number : (house) _____ (mobile) _____

(Please tick (✓) in the relevant box)

No	Medical Problems	Yes	No	*If 'Yes' please give details
1	Congenital or inherited disorder			
2	Allergies			
3	Mental illness			
4	Fits, stroke, other neurological disease			
5	Diabetes Mellitus			
6	Hypertension			
7	Heart or vascular disease			
8	Asthma			
9	Thyroid disease			
10	Kidney disease			
11	Cancer			
12	Tuberculosis			
13	Drug addiction			
14	AIDS, HIV			
15	Prior Surgeries			
16	Other illnesses			

**Details may be included in a separate sheet.*

No	Immunization History (where applicable)	Date of Immunization
1	Chickenpox	
2	BCG	
3	Meningitis (Quadrivalent)	
4	Hepatitis B	
5	Others:	

I hereby certify that the information given above is true.

…….. ……..

Signature of candidate Date

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Physical Examination *(To be filled by examining doctor)*

1. Basic Measurement

Height : _____ Weight: _____

Blood Pressure : _____ Pulse Rate: _____

Vision Test (Unaided) : R _____ L _____ Vision Test (Aided): R _____ L _____

Colour Vision Test : ❒ Normal ❒ Abnormal (Please specify) _____

2. General Examination

No	Item	Yes	No	*If Yes, please give details
a	Deformities			
b	Pallor			
c	Cyanosis			
d	Jaundice			
e	Oedema			
f	Skin Diseases			

3. Systemic Examination

No	Item	Normal	Abnormal	*If Abnormal, please give details
a	Eyes (including funduscopy)			
b	Ears			
c	Nose			
d	Oral Cavity/Throat			
e	Neck			
f	Heart			
g	Lungs			
h	Abdomen/Hernia Orifices			
i	Nervous System			
j	Mental Condition			
k	Musculoskeletal System			

**Details may be included in a separate sheet.*

Chest X-Ray Information

Please ensure the X-Ray Film is labeled with your name and date taken.
Chest X-Ray done within 6 months prior to registration can be accepted.

Chest X-Ray No : _____ Date Taken: _____

Place Taken : _____

Report : _____

_____

Certification by the Examining Doctor *(Please tick (✓) in the appropriate box)*

I certify that I have examined Mr/Ms _____

NRIC No _____ and found him/her:-

❒ In Good Health

❒ Having the following health related issue/s (please state)

_____

_____

❒ Undergoing treatment for (please state)

_____

_____

Signature of Doctor : _____

Name of Doctor : _____

Address : _____

_____

_____

Date : _____

Official Stamp:

Remarks by University:

The university reserves the right to repeat a full medical check-up or any specific laboratory tests.