



UNIVERSITY HEALTH CENTRE (HEALTH SERVICE) <u>Admission Medical Examination Report - Part Time Undergraduate Students (Local and International)</u>

Full Name:			Gender: Male / Fe						
(underline Surna	ame / Famil	y Name)							
Course of Study:	Email Address:								
NRIC / Passport No:	FIN No:								
Date of Birth:	Nationality (citizenship status):								
Home Address:									
Tel No (Handphone):	(Home):								
In case of emergency, person to contact:	n to contact: Relationship:								
Person's Contact No:		E	Email Address:						
1) Are you currently under treatment or have No Yes If "Yes", please provide details.	e been tre	eated for a	any long-term physical condition?						
2) Are you currently under treatment or have	e been tre	ated by a	a psychiatrist, clinical psychologist, or other mental health professional?						
☐ No ☐ Yes If "Yes", please provide details (diagnosis, tr	reatment,		d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr	reatment,	wing?	d duration, etc – Please use a separate sheet if necessary).						
☐ No ☐ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any or	reatment,	wing?	d duration, etc – Please use a separate sheet if necessary).						
☐ No ☐ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any or	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any of (Please Tick [✓] No or Yes. If "Yes" please	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tree Personal Medical History: Have you suffered from or undergone any of (Please Tick [✓] No or Yes. If "Yes" please Allergies	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any or (Please Tick [✓] No or Yes. If "Yes" please Allergies Acute/Chronic Respiratory Disorders	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any of (Please Tick [✓] No or Yes. If "Yes" please Allergies Acute/Chronic Respiratory Disorders Blood Disorders	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any or (Please Tick [✓] No or Yes. If "Yes" please Allergies Acute/Chronic Respiratory Disorders Blood Disorders Gastro-intestinal Disorders	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tree Personal Medical History: Have you suffered from or undergone any of (Please Tick [✓] No or Yes. If "Yes" please Allergies Acute/Chronic Respiratory Disorders Blood Disorders Gastro-intestinal Disorders Heart Disorders Injuries or Deformities	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
No	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
□ No □ Yes If "Yes", please provide details (diagnosis, tr Personal Medical History: Have you suffered from or undergone any or (Please Tick [✓] No or Yes. If "Yes" please Allergies Acute/Chronic Respiratory Disorders Blood Disorders Gastro-intestinal Disorders Heart Disorders Injuries or Deformities Kidney / Urinary Disorders Muscular / Joint Disorders	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						
Personal Medical History: Have you suffered from or undergone any or (Please Tick [✓] No or Yes. If "Yes" please Acute/Chronic Respiratory Disorders Blood Disorders Gastro-intestinal Disorders Heart Disorders Injuries or Deformities Kidney / Urinary Disorders Muscular / Joint Disorders (e.g. scoliosis)	reatment, f the following specify	wing?	d duration, etc – Please use a separate sheet if necessary).						

I hereby consent to NUS collecting and using the information I have provided herein for the purposes of evaluating my admission to NUS. Further, I hereby consent to NUS disclosing the information provided herein to NUS' insurers for the purposes of the insurers assessing my eligibility for insurance coverage.

Signature of Student:	Date:
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	(Note: To be co	ompleted by a re			I Examination) o is not a relative	of the student	t being examine	d)	
Student's Full N	ame:(underl	line Surname / Fam	nilv Name)			NRIC / Pass	oort No:		
	m	illo ournaine	шу тчао,	Weigh	:: kg				
Blood Pressure:	/	mmHg	Pulse f		Rate:	per minute			
/isual Acuity: l	Jncorrected: Righ	nt: 6 / Left	Left: 6 /			Colour Vision	n: 🗆 Normal	☐ Abnormal	
	Corrected: Righ	nt: 6 / Lef	t: 6 /						
Please examine	the following sys	tems and indica	nte anv abno	ermalities:					
					nse is <i>Abnormal</i> .)			
		Normal	Abno	ormal			Details		
Eyes (other t	han myopia)								
Respiratory									
Cardiovascu	lar								
Gastro-Intest	tinal								
Muscular/Sk	eletal								
Neurological									
Psychiatric									
	conditions, pleas	se indicate he	re:						
Urinalysis Test Date: Others (If Indicated)	Albumin: Sugar: Red Blood Cells:		Positive	Value	Urine FEME (If Indicated) Test Date:	RBCs Casts Trichomonas Reference Ra	_ Crystals s Occult B	Cs /µL ECs /µL Organisms	
(Please attach a student's name	a copy of the Ches and identity no. o	st X-ray report to	ogether with	this form t	•	a ✔): th Centre. The		ust be <i>in English</i> with	
Normal Abnormal				Remarks			Dat	te of X-ray	
CONCLUSIO	N (Please conclu	de and indicate	if student is	fit for studi	ies at NUS with a	√):			
	FIT U					Date o	f Examinatio	n	
Physician's Cor	mments (if applica	able):							
Physician's Name & Stamp :		Signatu	ıre:		Clinic Stamp and Address:				