Nālandā UNIVERSITY

STUDENT MEDICAL INFORMATION SHEET

This information is strictly for the use of Nalanda University Health Centre and will not be shared with any other without your knowledge or consent. All post graduate and Ph.D students entering Nalanda University are required to submit this sheet of Health History to the Nalanda University at the time of Admission. The report of Health History requires a physical examination completed by a licensed healthcare provider. It is recommended that a healthcare provider who is familiar with the student and his/her medical history may provide the report in the prescribed format after physical examination.

The purpose of this Report of Health History is: -

- To provide information in the event of a medical emergency.
- To assist the licensed staff of Health Services by providing health information that may not be immediately obtainable from the student.
- To assist students who are chronologically ill or physically challenged in maximizing their experience at Nalanda University.

(To be filled by the Student)

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1. Name (in block letters) :…………………………………………………………………………………..…

2. Father's Name :…………………..……………………………………………………………………..…

3. Mother's Name :…………………………………………………..……………………………………….……

4. Gender: Male/Female 5. Blood Group : .... 6. Date of Birth:………………… 7. Nationality: ..……………………..

8. Marital Status: Married/Single 9. School :……………………..…………………………………………………...

10. Email :…………………….…………………………… 11. Phone No : …………….……………………

12. Vegetarian/Non-Vegetarian 13. Smoking/tobacco cannabis? : Yes/No 14. Alcohol consumption: Yes/No

15. When were you immunized against the following diseases: COVID-19 ..….. …Typhoid ..…… Hepatitis B ....

16. Are you suffering from Hypertension, Diabetes Mellitus, Chronic Kidney Disease, Cancer, HIV/AIDS, Allergy, Anxiety/depression, (Please, attach the relevant documents)……………………………………………

17. History of Surgery, Hospitalization (Please, attach the relevant documents) ……………………..………………

18. Any other information about your health : ….……………………………………………………………...

19. Are you suffering from any psychological disorder? : ………………………………………………………..

20. Family history of psychological disorder? ………………………………………………………………………..

21. Are you suffering from any Asthma/ Seizure/ GIT/ Urinary problem/ Insomnia/ Communicable diseases? : ….…….

22. Do you follow a diet restriction? If yes please specify…………………………………………………………

23. Permanent Address : ……….………………………………………………………………………….

……….……………………………………………………………………………………………..

24. Emergency contact details: ……….…………..……………………………………………………

Signature of the Student

MEDICAL EXAMINATION REPORT

Note: Clinico-pathological investigations are to be performed from any government hospital/ diagnostic centre of your country.

Name of the candidate…………………………………………………………… Date of Examination…………………….

A. GENERAL PHYSICAL EXAMINATION:

1. Age :……………………. 2. Apparent : ………………………...
3. Built : Thin/Medium/Heavy 4. Nutrition : Adequate/Inadequate/ Obcsc
5. Height : ....……………cms 6. Weight : ………………….kg
7. Chest Normal :……………..…cms 8. Chest Expanded : ………………….cms
9. Abdominal Girth :…..…………. cms 10. Pulse Rate/Rhythm :……………..…BPM
11. Blood Pressure :…..……………mmHg 12. Skin/Hair/Nails : …………………………..……
13. Lymph Nodes (Cervical/Axillary/Inguinal : significantly palpable/non palpable)
14. Pallor : Present/Not Present 15. Pedal Oedema : Present/Not Present

B. SYSTEMIC EXAMINATION :

1. Eye (External) : …………………….....
2. Vision : RE/LE
3. Fundus Examination : …….………………....
4. Colour blindness: ………………..…….…………..
5. Neurological Examination: ……………………..
6. Ear/Nose/Throat/Dentition : …………………………...
7. Cardiovascular System : ………….……………….
8. Respiratory System :……………...……..…………..
9. Liver/Spleen : Palpable/Non-palpable
10. Bones/Joints/Muscles : ……..…………..…………
11. Hernia/Hydrocele/Varicose Veins : ….……………………………….………………………
12. Obstetric History/Gynecological Exam :…………..……………………………………………….

C. ANY LOCOMOTOR/HEARING IMPAIRMENT/VISUAL/NEUROLOGICAL DISABILITY :

D. LABORATORY INVESTIGATIONS:

1. Hemoglobin/ CBC :..……………..gm %
2. Blood Sugar Fasting ……PP ..…. mg% , HbA1c ...……
3. LFT : ……….………………
4. KFT : ……..………………………..
5. Lipid Profile : ..…………………..… (TSH)
6. HBsAg/HCV : ….. …………………………..
7. HCV- I / II : ……………………..
8. Urine R/E :……………Urine M/E……………
9. Chest X-Ray PA View : …….……………………
9. E.C.G : …………...………..…………………
10. Ultrasonography Abdomen / KUB : ….……..…………………………..

Remarks of Examining Medical Officer :

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Signature of the Medical Officer