BAPTIST COLLEGE OF THEOLOGY, OYO
P. M. B. 1088
OYO, OYO STATE

MEDICAL EXAMINATION FORM

Name of Hospital:……..

Address of Hospital:……..

……

Name of Candidate:……

Date:……Address:……

Sex:……..Age:…….. Married:…… Single:……

HISTORY: (To be completed by candidate)

HAVE YOU EVER HAD OR DO YOU HAVE: (IF SO STATE DATE AND DURATION)

1. Cough lasting over two weeks?.....
2. Blood in the stool?.....
3. Blood in the urine or after urination?.....
4. Eye troubles?.....
5. Ear trouble?.....
6. Epilepsy or Convulsion?.....
7. Hernia?.....
8. Heart trouble?.....
9. Enlarged glands in the neck?.....
10. Hepatitis
11. A. (Women) Menstrual irregularity?.....
    B. What is the date of your last menstrual period?.....
12. Any operations, accident or injuries?.....
13. Have you had bone pains and/or jaundice occasionally?.....

    ……
14. When was your last prolonged illness?.....
15. Yellow Fever Vaccination:…….. Date:……
16. Tetanus Vaccination:……Date of 1st dose……

    Date of 2nd dose:……Date of booster:……

PHYSICAL EXAMINATION

Temp.:…… Pulse: …… Resp.: …… WL.: …… B. P.: ……..

Eyes: Vision Right: …….. Left: …….. Breast: ……..

Ears:…….. Abdomen: …… Nose: ……

Teeth: …… Hernia: …….. Genitalia: ……

Mouth & Throat: …… Rectal: …… Neck: ……

Neurological: …….. Heart: …… Skin: …….. Lungs:……

LABORATORY STUDIES:

P. C. V.: …… Chest X-Ray No:…… X-ray findings: ……

Date: …….. Genotype: …… Blood Group:……

Wildal Test: …….. Urine: …… Stool:……..

Filarial Smear: …… Serology: ……

COMMENTS:

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Statement of fitness: ……

Date: …… Baptist Hospital: ……

Name of Doctor: ……

Signature & Stamp: ……