THE CLINIC GROUP

PRINT & PASTE LABEL HERE

- ☐ **THE CLINIC @ APERIA**
- ☐ **THE CLINIC @ BUSINESS CITY**
- ☐ **THE CLINIC @ CAMPUS**
- ☐ **THE CLINIC @ CAPITAGREEN**
- ☐ **THE CLINIC @ FUSIONOPOLIS**
- ☐ **THE CLINIC @ ONE GEORGE STREET**
- ☐ **THE CLINIC @ TAISENG**
- ☐ **THE CLINIC GROUP @ CAPITAL TOWER**
- ☐ **THE CLINIC GROUP @ MARINA ONE**
- ☐ **THE CLINIC GROUP @ WESTGATE**

# SMU PRE-ENROLMENT MEDICAL EXAMINATION REPORT

TO BE COMPLETED BY EXAMINEE:

| **PAST MEDICAL HISTORY** | **YES** | **NO** |
|---|---|---|
| 1. Congenital abnormalities | ☐ | ☐ |
| 2. Chronic illness on follow-up (diabetes, hypertension, etc.) | ☐ | ☐ |
| 3. Major illness (Dengue fever, pneumonia, etc.) | ☐ | ☐ |
| 4. Infectious diseases (Hepatitis, malaria, typhoid, etc.) | ☐ | ☐ |
| 5. Serious injuries, surgical operations or hospitalization | ☐ | ☐ |
| 6. Psychiatric illnesses | ☐ | ☐ |
| 7. Drug allergies | ☐ | ☐ |
| 8. Long term medication | ☐ | ☐ |
| 9. Are you pregnant? | ☐ | ☐ |

| **TUBERCULOSIS (TB) RISK ASSESSMENT** | **YES** | **NO** |
|---|---|---|
| 1. Have you been in contact with anyone diagnosed with TB? | ☐ | ☐ |
| 2. Have you been diagnosed with TB before? | ☐ | ☐ |
| 3. Have you been diagnosed with or is suffering from any condition that weakens the immune system (HIV, substance abuse, diabetes, kidney disease, cancer, rheumatoid arthritis, Crohn Disease etc.)? | ☐ | ☐ |

If you have indicated 'yes' in any of the above questions, please provide more information and any other significant information here:

_____

_____

☐ I HEREBY DECLARE THAT ALL INFORMATION GIVEN IS GENUINE AND TO THE BEST OF MY KNOWLEDGE. I AM FULLY AWARE THAT IF I WITH HOLD ANY RELEVANT INFORMATION, THIS EXAMINATION WILL BE VOID.

☐ I HEREBY GIVE MY CONSENT TO THE CLINIC GROUP TO RELEASE MY MEDICAL RESULTS FROM THIS EXAMINATION TO SINGAPORE MANAGEMENT UNIVERSITY'S OFFICE OF REGISTRAR.

_____ DATE

_____ NAME & SIGNATURE OF EXAMINEE

TO BE COMPLETED BY EXAMINER:

| **INVESTIGATION** | | **NORMAL** | **ABNORMAL** |
|---|---|---|---|
| 1. Urine Test: | Protein | ☐ | ☐ |
| | Sugar | ☐ | ☐ |
| 2. TB Risk Assessment: | | ☐ | ☐ |
| 3. If Abnormal for TB Risk Assessment and/or ICA Student Pass Check-up required, Chest X-ray is required: | | ☐ | ☐ |

**PHYSICAL EXAMINATION**

Height: _____m Weight: _____kg

Visual Acuity: ☐ Aided Right: ____/____ Left: ____/____

Pulse Rate: _____/min

Blood Pressure: _____/mmHg

| | **NORMAL** | **ABNORMAL** |
|---|---|---|
| Systems Review: ENT, Head, Neck, Lungs, Abdomen, Neurological, Musculoskeletal systems, Mental state & Skin | ☐ | ☐ |

**DOCTOR'S REMARKS ON ABNORMAL RESULTS & SIGNIFICANT FINDINGS**

_____

_____

**RECOMMENDATION**

☐ Fit for enrolment

☐ Fit for enrolment provided:

_____

_____

☐ Unfit for enrolment

_____ DATE & CLINIC STAMP

_____ NAME & SIGNATURE OF EXAMINER