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: Systolic: _____

Dystolic: _____

	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