

Bible College of Malaysia

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Mailing Address: P.O.BOX 141, 46710 PETALING JAYA, SELANGOR DARUL EHSAN, MALAYSIA.

MEDICAL QUESTIONNAIRE

Name: _____ Sex: _____ Status: _____
Date of Birth: _____ Height: _____ Weight: _____

Medical History:

- Past illnesses

<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Dysmenorrhoea	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Migraine
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Skin trouble	<input type="checkbox"/> Tuberculosis

- Past operations, accidents, injuries _____
- Immunisations (polio, tetanus, BCG) _____
- Medications _____
- Smoking _____ Alcohol _____ Drug addiction _____
- Family History _____
- Social/Psychiatric History _____

Physical Examination:

- Cardiovascular:
General vitality and endurance _____
pulse rate: _____ blood pressure: _____ dyspnoea: _____
apex beat: _____ heart sounds: _____ murmurs: _____
- Respiratory:
hoarseness _____ respiratory rate _____
chest sounds _____ chest expansion _____
- Abdomen
scars _____ hernia _____
organ enlargement _____ bowel sounds _____
- Genitourinary _____
- Musculoskeletal
limbs _____ spine _____
wasting _____
- Neurological
visual acuity with glasses _____ without glasses _____
colour vision _____ visual field _____
reflexes _____ power/tone _____
hearing _____ smell _____

Laboratory Tests:

Urinalysis protein/glucose _____
Blood count & other tests & Chest X-Ray (if relevant) _____
Hepatitis B _____ HIV _____
(Please attach blood test results of Hepatitis B and HIV)

General Comments:

In my opinion there is / there is no physical reason to prevent _____
from participating in any sports or physical education.

I should advise that special care be given for _____

Name of Medical Practitioner _____

Address _____

Signature

Date