

1. Name (in BLOCK letters):

## Aliah University

## DEPARTMENT OF NURSING MEDICAL EXAMINATION FORM FOR ADMISSION TO B. SC. NURSING COURSE

**Date of Examination: ....../ 2023** 

2. Age:					
3. Address:					
4. Family History:					
A. Have any of your relatives had a nervous or renal disorder?					
B. Have any of your relatives had tuberculosis?					
C. Have any of your relatives had an	ny chronic an	d/or debilitating disease?			
5. Personal History:					
Has applicant ever suffered from any of the following disease?					
A. Asthma:					
B. Tuberculosis:					
C. Cardiac Disease:					
D. Gastro Intestinal Disorder:					
E. Cholecystic/Chlelitihisis:					
F. Mental or Nervous Disabilities:					
G. Arthritis:					
H. Convultion:					
I. Any other specify (Surgeries, if an	ny):				
6. Had applicant have typhoid fever ora	anti-typhoid i	n oculation? Date when was			
applicant last successfully vaccinated.					
Against Tuberculosis:	Date:	Result:			
Hepatitis B vaccination:					
TT vaccination:					
Covid 19 vaccination: (Date)					
1st Dose:					
2nd Dose:					
Booster Dose:					

7. A. Physical Exar	nination:					
i. General devel	opment: Good/Fa	air/Poor				
Weight:	Height:	Chest Circumfer	ence:	Posture:		
ii. Any recent ch	nange in Weight?					
iii. Skin:						
iv. Ears:			Hearing:			
v. Eyes:	Right Eye:	Left Eye	: Colo	rblindness:		
vi. Conditions o	f Teeth & Gums:					
vii. Lungs:						
viii. Heart:	Pulse	Rate:	BP:			
ix. Varicose Vei	ins:					
x. Abdomen:	Girth:	Liver:		Spleen:		
xi. Nervous sys	tem:					
xii. Loco-motor system: (any abnormality)						
B. Blood:						
нв:	RI	RBC:		WBC:		
ESR:	1 <sup>st</sup> Hr.:		2	2 <sup>nd</sup> Hr.:		
Blood Group:						
Serology:	Hepatiti	is B:	Hepatitis C:	HIV:		
C. Urine Examination (RE/ME):						
Colour:	Specific Gravity:			Albumin:		
Sugar:	C	Cast:	Cell:			
D. Stool Examinati	on (RE/ME):					
E. Menstruation Regular does it interfere with her regular activities:						
Are there any facts known to you, not brought in the forgoing your examination,						
affecting or Likely to effect the health of the applicant.						
F. Report of X-Ray	Chest:					
Signature of the M	Iedical Officer:					
Registration Num	ber:					
Address:						
Date:			Offic	ial Seal		