ACM

CONFIDENTIAL

PART 1: STUDENT PERSONAL HEALTH FORM

(to be completed by the student)

This form has been designed to help you, your doctor and ACM to identify any health concerns that may require special consideration during your time with the University.

Please complete all sections of part one of this form. A doctor from Executive Healthcare will complete Part II. Take your completed form to your medical examination.

Following your examination, the whole form will be submitted to the Admissions Office at ACM as soon as possible. Please leave the form at Executive Healthcare

Name:

Examination/Student ID:

Country of birth:

Country of residence:

Date of birth:

Contact address (include postcode):

Contact telephone number(s):

E-mail address:

Your current health status

1. Do you have any significant health problems at present? Yes ☐ No ☐
   If yes, please specify:

2. Are you currently seeing your (a) doctor regularly for any reason, or attending a hospital as outpatient, or on a hospital waiting list for any procedure? Yes ☐ No ☐
   If yes, please give details:

3. Are you currently receiving any dental treatment? Yes ☐ No ☐
   Please give details:

4. Are you taking any regular prescription medication? Yes ☐ No ☐
   Please give details:

5. Do you smoke tobacco? Yes ☐ No ☐
   If so, how many per day?

6. Do you drink alcohol? Yes ☐ No ☐
   If so, how much per week:
   Have you ever had a problem controlling your drinking habits? Yes ☐ No ☐

7. Are you allergic to:

Drugs or medicines	Yes/No	Details:
Food	Yes/No	Details:
Insect bites or stings	Yes/No	Details:

   Do you carry adrenaline/epipen to treat severe allergic reactions? Yes ☐ No ☐

8. Is there a history of any of the following conditions in your family (parents or siblings)?
heart disease ☐ hypertension ☐ stroke ☐ diabetes ☐ epilepsy ☐ bleeding or blood clotting disorder ☐
cancer ☐ depression/anxiety/psychosis ☐ alcohol or drug dependency ☐ other ☐
If yes, please give details:

Medical checklist

Have you ever suffered from any of the following? Please give further details in the box 'additional information' below:	Yes/No	Approx date
9. High blood pressure		
10. Recurrent sore throats/tonsillitis		
11. Asthma or wheezing		
12. Pneumonia or pleurisy		
13. Tuberculosis		
14. Hernia		
15. Indigestion /ulcers		
16. Frequent diarrhoea/constipation/irritable bowel syndrome		
17. Jaundice or hepatitis		
18. Diabetes		
19. Headaches or migraine		
20. Giddiness/vertigo		
21. Fits, convulsions or epilepsy		
22. Anaemia		
23. HIV infection		
24. Sickle cell disease		
25. Any eye disease		
26. Excessive anxiety/panic disorder/phobias		
27. Depression		
28. Stress related problem (school or home)		
29. Any suicide attempt		
30. Any other medical condition(s)		
For Women Only		
31. Heavy, painful, irregular periods?		
32. Any problems during pregnancy		
33. Breast lumps, cysts, pain		
34. Current contraceptive use (if any)		
35. HPV vaccine? (highly recommended)		

Additional information on conditions (9-34) noted above:
Use the space below to give further details about dates, severity, treatment, duration, results of any investigations and medication prescribed

Immunization Status[Indicate the date on which each of these were given]

Measles, Mumps, Rubella (MMR) (two doses required Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____
Tetanus-Diphtheria (Td) Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____ Tetanus Booster (in past 10 years): Dose 1: _____/_____/_____
Chicken pox (Varicella)(2 doses required) Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____
Yellow fever (in past 10 years) Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____
Hepatitis B (three doses required) Dose 1: _____/_____/_____ Dose 2: _____/_____/_____ Dose 3: _____/_____/_____
List any other vaccination received but not mentioned above

Summary: Is there any other medical information you would like to give which you have not included already?

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Please document any particular concerns you may have related to your health while a student at ACM. Please discuss these with the doctor during your medical examination, or contact the Admissions Office/Administration.

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Declaration
Please read these statements carefully before signing:

- I hereby declare that all the foregoing answers are true and, to the best of my knowledge, I have not withheld any information. I understand that failure to disclose any existing or previous medical condition may invalidate my admission offer.
- I give permission for the contents of this form to be fused in my own interest by ACM. I give permission for the ACM Medical Adviser to contact my doctor for further medical information should this be required.

Signed: **Date:**

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PART 2: STUDENT PERSONAL HEALTH FORM

(to be completed by the examining doctor)

Surname	Given names	Sex	Age	Date of examination
Past medical history (please give details of any major illnesses, hospitalisation, injuries, surgical procedures, or anything you may feel important given that this person plans will be under stress for the next few years)				

General systems enquiry

Please ask this person about the following:	Tick if normal	Please provide full details in the space provided
General health		
Allergy history		
Eyes		
Ear, nose & throat		
Dental condition		
Respiratory		
Cardiovascular		
Urinary		
Gastro-intestinal		

Reproductive health and/or menstrual cycle		
Locomotor		
Skin		
Central nervous		
Other		

Physical examination

Height (ms) ----------	**Pulse** ----------	**Urinalysis:** **Blood** …….. **Protein** …….. **Glucose** …….
Weight (kgs) ----------	**Blood pressure** ----------	**Further urine investigations if indicated:**

	Tick if normal	**Please give details of any abnormalities**
General condition and appearance		
Eyes (pupils, fundi, visual fields, ocular movement)		
Ear, nose and throat		
Lungs and chest (include PEFR if asthmatic)		
Cardiovascular system		
Breast examination (only if indicated)		
Abdomen (note if hernia present)		
Genito-urinary system (vaginal or genital examination only if indicated)		
Rectal examination only if indicated		

Skin		
Back, joints and limbs		
Central nervous system (sensory, motor reflexes, equilibrium)		
Any additional comments about the candidate's physical status:		

Reaction to stress:
Please comment, as far as you can, on how you think this person would adapt to the stresses of living and working in an academic environment. Please take into account any previous psychological problems and this person's historical reaction to stress related problems.

Current medications

Please give details of current repeat prescriptions (including contraceptive pill and asthma inhalers)

	Name of medication	Dose	Frequency
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Laboratory investigations

We do not routinely require any laboratory tests performed unless you feel they are clinically indicated. However, if you have any results of recent investigations for this person, which you think may contribute to an assessment of their current health, please enclose details or document below.

Details of recent investigations/tests/referrals	
FBC and Blood film comments	
Hb electrophoresis	
Mantoux test. If positive do CXRay	
Blood group (if known):	**Most recent cervical smear (if applicable):** **Date: _____** **Result: _____**
Other relevant recent results of investigations, specifically those related to any recent or chronic medical condition (eg HbA1C, Hb, TFTs):	
Is this person currently awaiting test results, referral or review from any specialist agency or department. If yes, please give details:	

Final assessment

Given your examination of this person, their medical history and the findings of this examination:

- Would you consider them to be medically fit to work/study at the Accra College of Medicine?
  Yes **No**
- If medically fit, are there any specific recommendations you would wish to make for this person? Please give details:
- Will this person require any routine follow up during their time at ACM?
  Please give details:

Details of examining doctor

Name of examining doctor: **(please print)**	
Signature:	
Address:	**Practice stamp:**
Telephone number:	**E-mail address:**