IMPORTANT INFORMATION / INSTRUCTIONS FOR FILLING IN MEDICAL CHECK-UP FORM (ALSO KNOWN AS HEALTH EXAMINATION REPORT)

1. Medical check-ups are **COMPULSORY** for all newly appointed staff and for renewal of contract. It can be at IIUM Clinics (IIUM Sejahtera Clinic Gombak / Gambang, IIUM Poliklinik Primer Sejahtera Pagoh and IIUM Family Health Clinic Kuantan).
2. **NO** reimbursement for medical check-ups done at any facility other than IIUM Sejahtera Clinic Gombak / Gambang, IIUM Poliklinik Primer Sejahtera Pagoh and IIUM Family Health Clinic Kuantan.
3. Appointment for medical check-up will be given after registered as an IIUM staff.

The candidate is required to:

1. Download and print the Medical Check-Up Form from the link provided in IIUM Sejahtera Clinic website.
2. In order to prevent wastage, kindly ***print the form on both sides*** of the A4 papers.
3. Please read carefully and fill in all relevant sections in **CAPITAL LETTERS** and bring to the clinic on the day of appointment given.
4. **(COMPULSORY)** Affix a colour passport-size photograph (not older than 6 months) in the box provided.
5. To fill in **SECTION 1,2,3** completely
6. Write your full name and matric number legibly in the bar provided on top of each page.
7. Bring all the records of current or past medical / surgical treatment from any health care provider including care from an alternative medical practitioner and medicines (including herbal & vitamins) currently being taken to the clinic on the day of your appointment.

For **X-ray procedure**, please scan the QR code for further information

MALE

FEMALE

For **any further enquiries**, kindly call during office hour :-

IIUM Sejahtera Clinic (ISC), Gambang Campus	: 09-5183577
IIUM Sejahtera Clinic (ISC), Gombak Campus	: 03-64214444
Poliklinik Primer Sejahtera (PoPS), Pagoh Campus	: 06-9747550
Family Health Clinic (FHC), Kuantan Campus	: 09-5704444

IIUM Sejahtera Clinic

For Clinic Use:	
New Appointment	
Renew Contract	
Health Screening	

HEALTH EXAMINATION REPORT - (STAFF)

Passport size Photo

(compulsory)

SECTION 1 - PERSONAL DETAILS

FULL NAME (as per NRIC / Passport):			
NRIC NO. / PASSPORT NO:			
STAFF NO:			
KULLIYAH / DEPARTMENT:			
POSITION OFFERED:			
DATE OF BIRTH (ddmmyy):			
GENDER:	Male / Female	STATUS:	Single / Married / Divorce
NATIONALITY:		DISABILITY / OKU:	
ADDRESS:			
CONTACT NO.:			
EMAIL:			
NAME OF NEXT OF KIN / PARENTS: **(in case of emergency)**			
RELATION TO CANDIDATE:		CONTACT NO:	
ADDRESS: (Please state if different from above address)			

SECTION 1B – IMMUNISATION HISTORY

IMMUNIZATION HISTORY		(Please state the last date the vaccine taken)			
1.	BCG Vaccine (TB Vaccine)		5.	Meningococcal Vaccine	
2.	MMR Vaccine (Measles, Mumps and Rubella)		6.	Hepatitis B Vaccine	
3.	DTaP Vaccine (Diphtheria, tetanus & pertussis)		7.	Others: (Please specify)	
4.	Yellow Fever* (please state date)				

*A valid Yellow Fever vaccination certificate is mandatory for all travelers' coming from or having transited (more than 12 hours) through countries with risk of Yellow Fever transmission.

International candidate is required to bring along the International Certificate of Vaccination for verification of information.

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

SECTION 1C – Please tick (√) the relevant box.

Explain in detail if **you** or **family members (parents and siblings)** have any of the following medical problems / conditions:

LIST OF MEDICAL PROBLEMS / CONDITIONS		SELF		FAMILY		IF 'YES' PLEASE EXPLAIN
		YES	NO	YES	NO	
1.	Drug allergy					
2.	Smoking / Vaping (current / past)					
3.	Tuberculosis					
4.	Diabetes mellitus					
5.	Hypertension					
6.	Heart or vascular disease(s)					
7.	Bronchial asthma					
8.	Gastritis					
9.	Chronic constipation / diarrhea					
10.	Thyroid disorder					
11.	Kidney disease(s)					
12.	Urinary problem(s)					
13.	Hemorrhoids / piles					
14.	Currently pregnant (for female)					
15.	Menstruation problem (for female)					
16.	Recurrent painful & swollen joints					
17.	Swelling / Lump at any part of body					
18.	Epilepsy / Seizures					
19.	Congenital / Inherited disorder(s)*					
20.	Mental Illness(es)					
21.	Neurological disorder(s)**					
22.	Cancer					
23.	Disability / OKU					
24.	Slipped disc / Scoliosis					
25.	Hepatitis B / Hepatitis C					
26.	HIV / AIDS / Syphilis					
27.	Sexually transmitted disease(s)					
28.	Drugs use / abuse					
	Opiate					
	Methamphetamine					
	Amphetamine					
	Cannabinoids					
29.	History of blood transfusion					
30.	History of hospitalization / intubation					
31.	History of head injury					
32.	History of surgery					
33.	Other Illness(es) – not in the list					
34.	List of current medication(s) (if any)					

* Medical conditions present since birth

**Neurological disorders include Migraines, Stroke, Motor neuron disease, Dementia / Alzheimer's disease, and Parkinson's disease

If you have sought consultation for any of the above listed conditions, you are required to submit your medical report from your attending doctor.

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

SECTION 2 - TB SCREENING

1. Do you have any of the following symptoms for the **past one month**?

	√ or X		**√ or X**
Prolonged cough		Loss weight	
Night sweat		Coughing blood	
Loss appetite		Close TB contact (family members / co-workers / friends)	

Note: if candidate has any of the symptoms, further evaluation, and investigations (AFB sputum examination and chest Xray) need to be done for screening of TB

(Chest x-ray, blood test, and urine for drugs are not mandatory. However, if indicated or subjected to university's rules (i.e. candidates for medical / allied health sciences enrolment) and/or on examining doctor's request, all reports must be enclosed.)

SECTION 3 – MENTAL HEALTH QUESTIONNAIRE

		YES	NO
1.	Have you often been bothered by feeling down, depressed, or hopeless for the **past one month**?		
2.	Have you often been bothered by little interest or pleasure in doing things you like for the **past one month**?		

How often have you been bothered by the following problems, for the **past two weeks**?					
		Not at all	Several days	More than half the days	Nearly every day
3.	Feeling nervous, anxious, or on edge	0	+1	+2	+3
4.	Not being able to stop or control worrying	0	+1	+2	+3

I hereby certify that all information given above is true. I also understand that my application will be rejected and the consequences in case the information given was found false.

Candidate's signature

_____
Name (as per NRIC / Passport):
NRIC No:
Date:

Witness' signature

_____
Name:
NRIC / Passport No.:
Date:

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

CONSENT FORM FOR SEXUALLY TRANSMITTED DISEASES / DRUGS SCREENING

I, _____ NRIC/Passport No._____
Staff ID _____, hereby agree to undergo STDs / drugs screening at IIUM Sejahtera Clinic / POPs / FHC (when indicated). I fully understand the implications involved with the above-mentioned procedure.

_____
Signature
Full Name (as per NRIC / Passport):
NRIC / Passport No:
Date:

_____
Witness' Signature (by clinic's staff)
Full Name:
NRIC / Passport No:
Date:

(END OF PAGE FOR CANDIDATE SECTION)

(SECTIONS BELOW FOR DOCTORS AND MEDICAL PERSONNELS)

SECTION 4: EXAMINATIONS

A. GENERAL EXAMINATION		
Blood Pressure:	Pulse rate:	
	Left eye	Right eye
Visual Acuity (Unaided / Aided)		
Colour vision	Normal	Abnormal:

Height (m):	Weight (kg):	BMI:

B. ECG	
✧ ECG are compulsory for new staff, ROC if more than 40 years old ✧ For auxiliary police, need baseline ECG	NORMAL / ABNORMAL

Please attach the ECG tracing

C. SYSTEMIC EXAMINATION			
	NORMAL	ABNORMAL	COMMENT
SKIN			
EARS			
NOSE			
ORAL CAVITY & THROAT			
NECK			
HEART			
LUNGS			
ABDOMEN			
UROGENITAL			
SPINE			
MUSCULOSKELETAL			
NERVOUS SYSTEM			

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

D. MENTAL HEALTH ASSESSMENT					
General Appearance		Neat & tidy		Untidy	
Speech	Coherent	Yes		No	
	Relevant	Yes		No	
Mood	Depressed	Yes		No	
	Anxious	Yes		No	
	Irritable	Yes		No	
Affect		Appropriate		Inappropriate	
Thought	Delusion	Yes		No	
	Suicidality	Yes		No	
Perception	Hallucination	Yes		No	
Orientation	Time	Yes		No	
	Place	Yes		No	
	Person	Yes		No	

SECTION 5 - INVESTIGATIONS

A. URINE TEST	
Glucose	
Albumin	
Microscopic examination	

B. BLOOD TEST					
	Normal	Abnormal		Normal	Abnormal
Full blood count			Thyroid function test		
Renal profile			Hepatitis B antigen		
Liver function test			Hepatitis C antibody		
Fasting blood sugar			HIV antibody		
HBA1C			Lipid profile		
Uric acid			VDRL/ TPHA (VDRL reactive, for TPHA)		
Malaria Parasite ***(for International staff only)***					

Please print the test result and attach it with the form.

C. CHEST X-RAY				
DATE TAKEN				
PLACE TAKEN				
		NORMAL	ABNORMAL	COMMENTS
i.	Thoracic cage			
ii.	Heart shape & size			
iii.	Lung fields			
iv.	Mediastinum & Hilar region			
v.	Diaphragms & Costophrenic angles			
vi.	Spine / Scoliosis			
vii.	Overall Impression			

Chest X-ray is COMPULSORY for all new staff. If indicated for ROC and age more than 40 years old.

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

SECTION 6 – DENTAL HEALTH EXAMINATION

IT IS HEREBY CERTIFIED THAT:

Mr. / Ms. _____ I.C. No. / Passport No. _____ has undergone a dental examination on:_____ from _____ until _____ and was found having:

Good dental health		
Has dental problem	Infection	
	Caries	
	Periodontal disease	
	Tooth loss	
	Other	

Dentist's Signature

_____

Official Stamp: Date:

FULL NAME (as per NRIC / Passport) & NRIC / PASSPORT NO.

SECTION 7 – CERTIFICATION BY THE EXAMINING DOCTOR

It is hereby certified that:

Candidate has the following medical conditions:	List of medications
1.	a.
2.	b.
3.	c.
4.	d.
5.	e.
6.	f.

	Candidate is in a good health and fit to work
	Candidate has medical condition and fit to work
	Candidate has unsatisfactory medical check-up outcome and need further evaluation

Doctor's signature & Stamp

_____

Date:

For International Islamic University Malaysia (IIUM) Doctors Verification
(if candidate did medical check-up from any clinic other than ISC / FHC)

	Candidate is in a good health and fit to work
	Candidate has medical condition and fit to work
	Candidate has unsatisfactory medical check-up outcome and need further evaluation

Doctor's signature & Stamp

_____

Date: