

## **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 (ROC). 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. Staffs are advisable to **call or walk-in** to schedule medical check-up appointment.

### **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	
Post Doctoral Fellow	

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.

**SECTION 1C – Please tick (V) 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) as prescribed dosage(s)					

\* 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:

NRIC/Passport No.

**SECTION 2 - TB SCREENING**

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

	<b>✓ or X</b>		<b>✓ or X</b>
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

**SECTION 3 – MENTAL HEALTH QUESTIONNAIRE**

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

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

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

Witness' signature

Name (as per NRIC / Passport):

NRIC No.:

Date:

Name:

NRIC / Passport No.:

Date:

FULL NAME:

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

Witness' Signature (by Clinical Staff)

Full Name (as per NRIC / Passport):

Full Name:

NRIC / Passport No:

NRIC / Passport No:

Date:

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)		
Pinhole test		
Colour vision	Normal	Abnormal:
Height (m):	Weight (kg):	BMI:

B. ECG	
❖ ECG are compulsory for new staff & Renewal of Contract (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			

**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	

FULL NAME:

NRIC/Passport No.

**SECTION 5 - INVESTIGATIONS**

<b>A. URINE TEST</b>	
Glucose	
Protein	
Microscopic examination	

<b>B. BLOOD TEST</b>		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 <i>(for International staff only)</i>						

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

<b>C. CHEST X-RAY</b>				
DATE TAKEN	PLACE TAKEN	(refer to Ac. Nb on the xray)		
X-ray Reference Number		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 Renewal of Contract (ROC) and age more than 40 years old.

FULL NAME:

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

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Official Stamp:

Date:

FULL NAME:

NRIC/Passport No.

## **SECTION 7 – CERTIFICATION BY THE EXAMINING DOCTOR**

It is hereby certified that:

Candidate has the following medical conditions:

List of medications with prescribed dosage(s)

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: