KUMASI CENTRE FOR COLLABORATIVE RESEARCH IN TROPICAL MEDICINE

Medical Examination

Name:………………………………………………………… Age: …………… Date of birth:……………………………

Department/Research Group:………………………………..

SECTION I. To be filled by applicant with the help of a Nurse or examining Physician, if necessary.

A. Have you ever suffered from or been advised that you have: (Circle Yes/No, where applicable)

1. Fits/Convulsion or Fainting Spells Yes No
2. Depression or any other mental illness Yes No
3. Anaemia Yes No
4. Sickle Cell Disease Yes No
5. Jaundice Yes No
6. Tuberculosis Yes No
7. Bronchitis Yes No
8. Pneumonia Yes No
9. Colitis Yes No
10. High Blood Pressure Yes No
11. Diabetic mellitus Yes No
12. Yaws Yes No
13. Leprosy Yes No
14. Gonorrhoea Yes No
15. Syphilis Yes No
16. Drug or Alcohol abuse problem Yes No
17. Asthma Yes No
18. Other Allergies Yes No
19. Chicken Pox Yes No
20. Typhoid Fever (Enteric fever) Yes No
21. Peptic ulcer Yes No

B. Have you ever been admitted to a Hospital, Health Centre or Clinic? Yes No
If the answer is 'Yes", please give details below.

Disease or Injury	Date	Duration	Name & Address of Doctor or Hospital

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C. In the case of a female:

I. Have you ever had any Obstetric or Gynaecological problem or operation? Yes No

If the answer is 'Yes", please give details below.

Obstetric or Gynaecologic procedure	Date	Duration	Name & Address of Doctor or Hospital

D. Immunization Record

Vaccine name	Check box where appropriate		If given, Date(s) given or administered
	Not done	Don't know	
BCG			
OPV			
DPT			
Yellow fever			
Measles			
H. influenzae type B			
Hepatitis B			

E. Family Record:

Has any member of your family ever had:

Tuberculosis	Yes	No	Myocardial Infarction (Heart Attack)	Yes	No
Asthma	Yes	No	Cancer	Yes	No
Epilepsy	Yes	No	Sickle Cell disease	Yes	No
Mental Disorder	Yes	No	Obesity	Yes	No
Hypertension	Yes	No	Allergic Condition(s)	Yes	No
Stroke	Yes	No	G6PD deficiency	Yes	No

F. Declaration:

I ………………………………………………………………………………… declare that the forgoing answers are true and that no pertinent aspect of my medical history has been withheld.

Signature of Employee:………………………………… Date:……………………………………………….

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Medical Examination

SECTION II

Examining Physician's Findings

This is to certify that on ………………………………………………………………… I examined applicant

Prof./Dr./Mr./Mrs./Ms:………………………………………………………………… Aged……………………………

Of (Home Town/Address)………………………………………………and the following were my findings.

General appearance:……

Height (in cm):…………………… Weight (in kg)…………………… Skin:…………………………………………………

Blood Pressure:……………………………… Rate and Nature of Pulse:……………………………………………

Heart:………

Lungs:………

Chest X-Ray, dated:……………………………………………………………………………………………………

Abdomen:………

C.N.S:………

Locomotor System:………………………………………………………………………………………………………

Ear/Nose & Throat:………………………………………………………………………………………………………

Teeth & Gums:………

Visual Acuity: Left Eye……………………………… Right Eye:……………………………

Laboratory Investigations

1. Blood: Haemoglobin…………… Sickling……………………
   Hb-Genotype (if Indicated)……………… HBSAg:……………………
   HCV AB test…………. Blood group/Rh (if indicated)…………
2. Urine Albumin:
   Sugar:………………………… SG:………………………………
   C/Deposit:…………………… Protein………………………
3. Sputum (if indicated):
   ………

Additional Remarks:

………

………

………

In view of the above findings, I declare him/her FIT/UNFIT for employment.

Name: ………………………………………………………………………………………………

Signature: ……………………………………………………………………………………….

Official Position: ………………………………………………………………………………

Address/Stamp: ……………………………………………………………………………….

Date: ……………………………………………………………………………………………

(Kindly complete the certificate of fitness)

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Medical Examination

LABORATORY REPORT

NAME OF EMPLOYEE: ……………………………………………………………………

SEX…………………..AGE…………………....

DEPARTMENT/ RESEARCH GROUP: ………………………………………………………

Date	Specimen	Examination	Result	Signed
	BLOOD	**Haemoglobin**		
		Sickling		
		HBsAg		
		HCV Ab test		
	URINE	**R/E**		
		C/S (where indicated)		

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Medical Examination

CHEST X-RAY REPORT

NAME OF EMPLOYEE: ……………………………………………………………………

SEX…………………..AGE………………......

DEPARTMENT/ RESEARCH GROUP: ……………………………………………….…

DATE:

CHEST XRAY DONE: Yes No

SUMMARY OF CHEST XRAY REPORT:

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Sign:

Date: