KIBU-F-ADM-022

# KIBABII UNIVERSITY

**MEDICAL EXAMINATION ON FIRST APPOINTMENT**

1. NAME: …………………………………………………………………………………………

2. ADDRESS: ……………………………………………………………………………………

3. APPOINTMENT: ……………………………………………………………………………..

4. NATURE OF WORK FOR PAST FIVE YEARS: ……………………………………………

5. DATE OF BIRTH: …………………………………. HEIGHT: …………WEIGH:…………

1. CARDIOVASCULAR SYSTEM
	1. Blood pressure (lying down) systolic………………. Diastolic………………………. ii) Apex beat………………………………………………………………………………. iii) Pulse rate………………………………………………………………………………. iv) Auscultations………………………………………………………………………….. v) HB (if possible)……………………………………………………………………….. vi) Varicose………………………………………………………………………………..
2. RESPIRATORY SYSTEM

i) Upper respiratory tract…………………………………………………………………. ii) Expansion (inches)…………………………………………………………………….. iii) Auscultation…………………………………………………………………………… iv) X-ray………………………………………………………………..(not mandatory)

1. ALIMENTARY SYSTEM

i) Spleen………………………………………………………………………………….. ii) Liver…………………………………………………………………………………… iii) Hernia………………………………………………………………………………….. iv) Other abnormalities…………………………………………………………………….

1. GENITAL-URINARY SYSTEM

i) Urine: Sp……………………Albumin………………………Sugar…………………..

v) Serology/Elisa…………………………………………….………..(not mandatory)

1. GENERAL NERVOUS SYSTEM

i) Fundi……………………………………………………………………………………

ii) Vision (R)…………………………………(L).............……………………………......

iii) Hearing (whispered voice) (R)…………………………(L)…………………………... iv) Tone and power………………………………………………………………………… v) Reflexes…………………………………………………………………………………

1. GIVE DETAILS OF ANY OTHER HISTORY OF DISEASES, ACCIDENT OR ABNORMALITY

i) …………………………………………………………………………………………

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ii) Higher Centers………………………………………………………………………..

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1. IS THE CANDIDATE FIT AND HEALTHY FOR HIS AGE?

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……………………………………………………………………………………………………… (If any has been discovered, please on its likely effect on the examinee’s health and fitness for the proposed appointment)

1. PLEASE COMMENT BELOW ON ANY MATTERS WHICH SHOULD BE CONSIDERED PERTINENT TO THIS EXAMINATION.

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Medical Officer’s Signature……………………………………….. Name in Block Letters……………………………………………... Address…………………………………………………………….. Date…………………………………………………………………

# FOR USE OF UNIVERSITY DOCTOR

Acceptable/Not acceptable

Signature …………………………………………………… Date………………………………………………………….

The candidate should send the completed forms (in duplicate) under confidential cover, directly to:-

# The Deputy Clinical Officer Kibabii University

**P.O. Box 1699, 50200 BUNGOMA**