



STUDENT MEDICAL FORM

Student Information

Student's Name:	Nat'l. ID / IQAMA:	PMU ID:
Date of Birth:	Nationality:	
Phone Number:		
Emergency contact numbers:		

Personal History

Height:	Weight:	BP:	HR:	RR:
Last Menstrual Period (Female):				

This report is to be completed by a licensed practising physician after a thorough physical examination of the student.

Description	Yes	No	Remarks
Hearth diseases or Rhythm abnormalities			
High blood pressure			Last Attack Highest BP
Rheumatic fever			
Asthma			
Pneumonia			
Chronic cough			
Allergic Rhinitis			
Recurrent headache or Migraine			
Diabetes			
Thyroid problems			
Kidney disorders (specify)			
Skin Diseases (specify)			
Anemia/ Sickle cell anemia			
Hepatitis			
Severe or recurrent abdominal pain			
Gastric/ Duodenal Ulcer			
Surgery (specify)			Date:
Bone/ Joint Diseases			
Eye problems			
G6PD			
Cancer (specify)			
Anxiety			
Depression			
Seizure Disorder			
Blood type A / B / AB / O	Rh+	Rh-	
Immunization/ MMR			
Hospitalizations (specify)			
On medication (list any medication you take on a regular basis)			
Psychological Problem: _____ On medication : _____			
Tobacco use :			

Family History

Do any family members have any health problem?			
If (yes) please specify			

Physician's Note:

Doctor's Name and Signature