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# LAPORAN PEMERIKSAAN KESIHATAN

Gambar ukuran paspot (*Passport size photo)*

**SILA ISI MENGGUNAKAN HURUF BESAR**

**BAHAGIAN 1 –** Untuk Diisi Oleh Calon

**NAMA PENUH**

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**KEWARGANEGARAAN**

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**NO. MyKAD NO. TELEFON**

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| **TARIKH LAHIR UMUR JANTINA STATUS PERKAHWINAN** |
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| T | T | B | B | T | T |  |  |  | P |  | KAHWIN |

**TAHUN AKADEMIK KOD KURSUS**

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**FAKULTI**

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**NAMA IBU BAPA / PENJAGA**

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**ALAMAT IBUBAPA / PENJAGA**

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**NO. TELEFON IBU BAPA / PENJAGA**

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**HUBUNGAN**

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**BAHAGIAN 2** - Sila tandakan (√) dalam kotak yang berkenaan

Pengisytiharan tahap kesihatan diri sendiri dan keluarga. Sila maklumkan dengan jelas jika anda atau ahli keluarga anda menghidapi penyakit-penyakit berikut. Ahli keluarga adalah ibu, bapa dan adik beradik.

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| **MASALAH PERUBATAN** | **SENDIRI** | **KELUARGA** | **Jika “Ya” sila nyatakan *penyakit dan rawatan yang diterima*** |
| **Ya** | **Tidak** | **Ya** | **Tidak** |
| 1. Kecacatan kekal atau penyakit diwarisi / *Congenital or inherited disorder* |  |  |  |  |  |
| 2. Alahan / *Allergy* |  |  |  |  |  |
| 3. Penyakit mental / Mental illness |  |  |  |  |  |
| 4. Sawan, angin ahmar, penyakit saraf yang lain / *Fits, stroke, other neurological disease* |  |  |  |  |  |
| 5. Kencing manis / *Diabetes Mellitus* |  |  |  |  |  |
| 6. Darah tinggi / *Hypertension* |  |  |  |  |  |
| 7. Penyakit jantung atau kardiovaskular / Heart or cardiovascular disease |  |  |  |  |  |
| 8. Lelah / *Asthma* |  |  |  |  |  |
| 9. Penyakit tiroid / *Thyroid disease* |  |  |  |  |  |
| 10. Penyakit buah pinggang /*Kidney disease* |  |  |  |  |  |
| 11. Kanser / *Cancer* |  |  |  |  |  |
| 12. Batuk kering / *Tuberculosis* |  |  |  |  |  |
| 13. Ketagihan dadah / Drug addiction |  |  |  |  |  |
| 14. AIDS, HIV |  |  |  |  |  |
| 15. Sejarah pembedahan / *History of surgery* |  |  |  |  |  |
| 16. Hepatitis B/C |  |  |  |  |  |
| 17. Merokok / *Smoking* |  |  |  |  |  |
| 18. Kecacatan anggota, pancaindera/ *Deformity of limbs or sensory organ* |  |  |  |  |  |
| 19. Penyakit lain / *Other illnesses* |  |  |  |  |  |

## BAHAGIAN 3

\* Sekiranya perlu, pelajar adalah dinasihatkan untuk mendapatkan pelalian yang berkaitan dengan nasihat Pegawai Perubatan

|  |  |
| --- | --- |
| **SEJARAH IMUNISASI – jika berkenaan** | **TARIKH IMUNISASI** |
| 1. BCG |  |  |  |  |  |
| 2. Hepatitis B |  |  |  |  |  |
| 3. Rubella |  |  |  |  |  |
| 4. Yellow Fever |  |  |  |  |  |
| 5. Meningococcal |  |  |  |  |  |
| 6. Typhoid |  |  |  |  |  |
| 7. Influenza |  |  |  |  |  |
| 8. Lain-lain / *Others* |  |  |  |  |  |

Saya dengan ini mengesahkan bahawa maklumat di atas adalah benar. Saya sedia maklum bahawa permohonan saya akan ditolak sekiranya maklumat yang diberikan tidak benar. Saya dengan ini memberi keizinan agar Laporan Pemeriksaan Kesihatan ini diserahkan kepada pihak Universiti.

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| Tarikh |  | Tandatangan calon No. Kad Pengenalan:( ) |

**BAHAGIAN 4 – PEMERIKSAAN FIZIKAL UNTUK DIISI OLEH PEGAWAI PERUBATAN YANG MEMERIKSA**

***PART 4 - PHYSICAL EXAMINATION***

*To be filled by Examining Doctor*

|  |
| --- |
| **1. BASIC MEASUREMENT** |
| HEIGHT : m | BLOOD PRESSURE : mmHg |
| WEIGHT : kg | PULSE RATE : / min |
| BMI : kg/m2 |  |
| VISION TEST : Unaided : (R) (L) Aided : (R) (L)  | COLOUR VISION TEST :NORMAL / ABNORMAL |

|  |
| --- |
| **2. GENERAL EXAMINATION** |
| **ITEM** | **YES** | **NO** | **COMMENT** |
| DEFORMITIES |  |  |  |
| PALLOR |  |  |  |
| CYANOSIS |  |  |  |
| JAUNDICE |  |  |  |
| OEDEMA |  |  |  |
| SKIN DISEASES |  |  |  |

|  |
| --- |
| **3. SYSTEMIC EXAMINATION** |
| **ITEM** | **NORMAL** | **ABNORMAL** | **COMMENT** |
| EYES (including funduscopy) |  |  |  |
| EARS |  |  |  |
| NOSE |  |  |  |
| ORAL CAVITY / THROAT |  |  |  |
| NECK |  |  |  |
| HEART |  |  |  |
| LUNGS |  |  |  |
| ABDOMEN / HERNIA ORIFICES |  |  |  |
| NERVOUS SYSTEM |  |  |  |
| MENTAL CONDITION |  |  |  |
| MUSCULOSKELETAL SYSTEM |  |  |  |

## BAHAGIAN 5 – UJIAN DIAGNOSTIK

***PART 5- Diagnostic Test***

|  |
| --- |
| **URINE TEST** |
| **ITEM** | **DATE TAKEN** | **RESULT** |
| ALBUMIN |  |  |
| SUGAR |  |  |

|  |
| --- |
| **CHEST X-RAY INFORMATION (IF INDICATED)** |
| CHEST X-RAY NO. |  |
| DATE TAKEN |  |
| PLACE TAKEN |  |
| REPORT |  |
|  |

# BAHAGIAN 6 – PENGESAHAN PEGAWAI PERUBATAN

***PART 6* - *Certification by the Examining Doctor***

I hereby certify that I have examined with MyKAD No. / Passport No. on this date and found him/her:

IN GOOD HEALTH

HAS MEDICAL PROBLEM (Please state)

IS UNDERGOING TREATMENT FOR: (Please state)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | : |  | Signature of Doctor | : |
|  |  |  | Name of Doctor | : |
|  |  |  | Qualification & | : |
|  |  |  | Official stamp of Clinic |  |

**Remarks by Universiti Pendidikan Sultan Idris’s Medical Officer:**

Normal

Signature and official stamp:

Has medical problem (please state):

………………………………………….

Date:



## BAHAGIAN 7

Nama

No Matrik No MyKAD

No Telefon

:

:

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**PERAKUAN KEBENARAN BIUS *(ANAESTHESIA)* DAN PEMBEDAHAN**

Pegawai Perubatan

**Universiti Pendidikan Sultan Idris 35900 Tanjong Malim**

**PERAK**

Saya No MyKAD

 bapa/ibu/penjaga kepada (Nama Calon)

 dengan ini memberi kuasa kepada tuan untuk menandatangani kebenaran bagi pihak saya, jika pada pandangan doktor yang calon ini memerlukan rawatan bius (*anaesthesia*) atau/dan pembedahan, sedangkan saya tidak dapat hadir pada masa yang diperlukan.

Saya tidak akan mendakwa atau mengambil sebarang tindakan terhadap Universiti Pendidikan Sultan Idris jika berlaku sebarang kemungkinan yang timbul daripada prosedur tersebut.

**Nama Bapa/Ibu/Penjaga Yang benar,**

Alamat

**Tandatangan Bapa/Ibu/Penjaga**

Nombor Telefon : Tarikh :