



UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES (DUHS)
PROCEDURES FOR STUDENT MEDICAL EXAMINATION

1. Download the following forms from the University website:
 - i. *Confidential Medical Report*
 - ii. *Laboratory Report*
 - iii. *X-ray Form*
 - iv. *Fresh Students' Oral Screening Form*
 - v. *Eye Screening Form & Fresh Students' Eye Examination Report*
2. Portions of the forms must be filled by Students appropriately.
3. Visit the Laboratory Unit of the University Hospital with the **Laboratory report form** to collect **specimen containers**, and also for your blood sample to be taken.
4. Please report at the X-ray Unit with the **X-ray form** for the necessary procedures to be done.
5. Please visit the Dental Clinic with the **oral form** for the oral examination.
6. Please report at the Eye Clinic with its forms for the eye screening.
7. Kindly go back to the Laboratory and X-ray Units for the respective results, and proceed to the OPD for procedures on **weight, height, and blood pressure**.
8. The OPD In-Charge will schedule your consultation with a Medical Officer for the medical examination and completion of the **Confidential Medical Report**.
9. A **hospital records card** would be issued to you by the Health Informatics & Records Unit (HIRU) after the consultation with the Medical Officer.
10. The original copy of the **Confidential Medical Report** should be submitted to the **Directorate of Academic Affairs** for further action. Students are advised to keep photocopies of the **Confidential Medical Report** for future references.



UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES (DUHS)
CONFIDENTIAL MEDICAL REPORT

NAME:.....REG.No:.....

SECTION 1. To be filled by applicant with the help of a nurse or examining physicians, if necessary.

A. Have you ever suffered from or been advised that you have: (Underline 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. Peptic Ulcer | Yes | No |
| 10. Colitis | Yes | No |
| 11. High Blood Pressure | Yes | No |
| 12. Diabetic mellitus | Yes | No |
| 13. Yaws | Yes | No |
| 14. Leprosy | Yes | No |
| 15. Gonorrhoea | Yes | No |
| 16. Syphilis | Yes | No |
| 17. Drug or Alcohol problem | Yes | No |
| 18. Asthma | Yes | No |
| 19. Other Allergies | Yes | No |
| 20. Chicken Pox | Yes | No |
| 21. Typhoid Fever (Enteric fever) | Yes | No |

B. Have you ever been admitted to a Hospital, Health Centre or Clinic? Yes/No,

C. In the case of a female applicant:

- i. State the date of your Last Menstrual Period (LMP)
- ii. Have you ever had any Obstetric or Gynaecological problem or operation? Yes/No

D. If the answer to any of the questions is ‘Yes’, please give details below.

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

E. Family Record:

Has any member of your family ever had:-

- | | | | | | |
|-----------------|-----|----|-----------------------------------|-----|----|
| Tuberculosis | Yes | No | Myocardial Infarct (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 | G.6 PD – Deficiency | Yes | No |

F. Declaration:

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

Name of Witness:.....

Signature of Applicant:.....

Signature of Witness:.....

Date:.....

SECTION II

Examining Physician’s Findings

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

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:.....

Eyes: Left Ext..... Pupil/Accommodation.....V.A:.....

Right Ext:..... Pupil/Accommodation.....V.A:.....

Laboratory Investigations

- 1. Blood: Haemoglobin..... Sickling..... Hb-Genotype (if Indicated).....
Blood group/Rh (if indicated).....
- 2. Skin snip (if indicated)
- 3. Urine Albumen:
Sugar:.....
SG:.....
C/Deposit:.....
- 4. If female: Pregnancy test 9if indicated)
- 5. Sputum (if indicated)

Additional Remarks:.....
.....
.....

In view of the above findings, I declare him/her FIT/UNFIT for admission/employment/to travel outside Ghana.

Signature:.....

Official Position:.....

Adress/Stamp:.....

Date:.....



**UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES-DUHS
FRESH STUDENTS' ORAL SCREENING FORM**

Name: Sex:.....Age:.....

Programme.....Registration No:.....

Part B – Dental Surgeon’s Findings

<p>Teeth Present</p> <table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 50%;"></td><td style="width: 50%; height: 50%;"></td></tr> <tr><td style="width: 50%; height: 50%; text-align: center;">Filled Teeth</td><td style="width: 50%; height: 50%;"></td></tr> </table>			Filled Teeth		<p>Decayed Teeth</p> <table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="width: 50%; height: 50%;"></td><td style="width: 50%; height: 50%;"></td></tr> <tr><td style="width: 50%; height: 50%; text-align: center;">Missing Teeth</td><td style="width: 50%; height: 50%;"></td></tr> </table>			Missing Teeth	
Filled Teeth									
Missing Teeth									

Other Conditions Present

- 1).....
- 2).....

Dental Surgeon’s Remarks

.....
.....

Signature

Date:



**UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES-DUHS
FRESH STUDENTS' ORAL SCREENING FORM**

Name: Sex:.....Age:.....

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Part B – Dental Surgeon’s Findings

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Filled Teeth									
Missing Teeth									

Other Conditions Present

- 1).....
- 2).....

Dental Surgeon’s Remarks

.....
.....

Signature

Date:



UNIVERSITY OF CAPE COAST
COLLEGE OF AGRICULTURE & NATURAL SCIENCES
SCHOOL OF PHYSICAL SCIENCES
DEPARTMENT OF OPTOMETRY

EYE SCREENING FORM

Name:

Index No:

Age: Sex: M/F

Phone Number:

Fathers Occupation:

Fathers academic qualification:

Mothers Occupation:

Mothers academic qualification:

Please complete this questionnaire, After each symptom listed, circle the number that best describes how often you experience that particular problem. 0=never, 1=(not very often) infrequently, 2=sometimes, 3=fairly often, 4=always		
1	Do your eyes feel tired when reading or doing close work?	0 1 2 3 4
2	Do your eyes feel uncomfortable when reading or doing close work?	0 1 2 3 4
3	Do you have headaches when reading or doing close work?	0 1 2 3 4
4	Do you feel sleepy when reading or doing close work?	0 1 2 3 4
5	Do you lose concentration when reading or doing close work?	0 1 2 3 4
6	Do you have trouble remembering what you read?	0 1 2 3 4
7	Do you have double vision when reading or doing close work?	0 1 2 3 4
8	Do you see the words move, jump, swim or appear to float on the page when reading or doing close work?	0 1 2 3 4
9	Do you feel like you read slowly?	0 1 2 3 4
10	Do your eyes ever hurt when reading or doing close work?	0 1 2 3 4
11	Do your eyes feel sore when reading or doing close work?	0 1 2 3 4
12	Do you feel "pulling" feeling around your eyes when reading or doing close work?	0 1 2 3 4
13	Do you notice the words blurring or coming in and out of focus when reading or doing close work?	0 1 2 3 4
14	Do you lose your place while reading or doing close work?	0 1 2 3 4
15	Do you have to reread the same line of words when reading?	0 1 2 3 4
	Total Score	0 1 2 3 4

Please tick or fill space appropriate		YES	NO
1	Have you ever been prescribed glasses		
	If yes, were you able to obtain/purchase it?		
	If No, indicate the reason		
	If yes, Do you frequently wear it?		
	If No, indicate the reason		
	Who, where and when was it prescribed?		
	Do you know why the glasses were prescribed?		
	If yes, can you state it?		
	Does any member of your family wear glasses?		
	If yes, please list them		
	For what purpose do they wear the glasses		
2	Have you heard about GLAUCOMA?		
	If yes, where did you hear about it?		
	In your own words, what is glaucoma?		
	Have you been tested for glaucoma?		
	If yes, what was the result of the test?		

		YES	NO
3	Do you have a blind person in your family		
	If yes, do you know the cause of the blindness?		
	Can you name the cause of the blindness?		
4	Do you always avoid sunlight?		
5	Are you a frequent user of laptops or smart phones?		
	If yes, do you often feel burning sensation after prolonged use of the laptops or smart phones?		
	Do tears come out from your eyes when using them?		
	Do you feel like there is an object on your eye which you can't remove?		
	Do your eyes become red often?		
6	Do you have any medical condition? E.g. asthma, Diabetes, Hypertension etc.		
	If yes, please specify		
7	Does your eye itch often?		
8	Do you know your sickle cell status?		
	If yes, are you positive?		
	If positive, what is your genotype? SS, AS etc.		
	What is the most disturbing eye problem you have?		

CLINICAL USE

	UNAIDED		+100 <input type="checkbox"/> PH <input type="checkbox"/>	WITH SPECTACLE RX					CONTACT LENSES	VA	AOA
			SPH	CYL	AXIS	@6M	@0.4M				
OD											
OS											
				DATE OBTAINED							

NPC	COVER TEST	OCULAR MOTILITY	PUPILARY REFLEX		CONFRONTATION	
	PHOPIA <input type="checkbox"/> TROPIA <input type="checkbox"/>	OD OS	DIRECT		OD	OS
	MAG:		CONSENSUAL			
			NEAR			

EXTERNALS	OD:	
	OS:	
INTERNALS E/CD/D/...	OD:	
	OS:	
OTHER FINDINGS:		

DOCTORS REPORT REFERRED NOT REFERRED (TICK)

REASON FOR REFERRAL/DX:

INTERVENTION GIVEN:

.....

.....

SIGN/STAMP



UNIVERSITY OF CAPE COAST
 COLLEGE OF AGRICULTURE & NATURAL SCIENCES
 SCHOOL OF PHYSICAL SCIENCES
 DEPARTMENT OF OPTOMETRY
FRESH STUDENTS EYE EXAMINATION REPORT

Name: Age:

Registration No:.....Date:.....

FINDINGS

VISUALS ACUITY

Right Eye..... Left Eye.....

EXTERNAL EXAMS

Right Eye.....

Left Eye.....

INTERNAL EXAMS

Right Eye.....

Left Eye.....

REFRACTIVE STATUS

ADDITIONAL REMARK.....

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

Signature:

OPTOMETRIST



UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES (DUHS)
X'RAY FORM

NAME OF STUDENT:.....SEX.....AGE.....

REG No.:HALL OF AFFILIATION:

PROGRAMME:

BRIEF HISTORY: **MEDICAL EXAMS**

.....

.....

X'Ray Required: **CHEST**

.....

Date:

.....
UHS
Senior Medical Officer



**UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES (DUHS)**

LABORATORY REPORT

PATH No.:

NAME OF STUDENT:SEX.....AGE.....

REG No.: HALL OF AFFILIATION:

PROGRAMME: PHONE NO.:

SHORT HISTORY/IMPRESSION: **MEDICAL EXAMS**

HEPATITIS B VACCINATION: YES/NO NUMBER OF SHOTS:

REFERRAL M.O. **UHS**

Date	Specimen	Examination	Result	Signed	Lab. No.
	BLOOD	HB			
		SICKLING			
		HEPATITIS B			
		HEPATITIS C			
	URINE	RIE	PROTEIN: SUGAR:		
			DEPOSIT:		

