



**HEALTH EXAMINATION GUIDELINES  
FOR ENTRY INTO  
MALAYSIAN HIGHER EDUCATIONAL INSTITUTIONS**  
(Required by the Government of Malaysia)

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN THE **ENGLISH** LANGUAGE.
3. PLEASE WRITE IN **CAPITAL LETTERS**.
4. THIS FORM HAS 4 SECTIONS:
  - (a) SECTION 1 (PART A AND B) TO BE FILLED BY THE CANDIDATES; AND
  - (b) SECTION 2, 3 AND 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY ONLY ACCEPTS MEDICAL EXAMINATIONS DONE WITHIN **60 DAYS** BEFORE REGISTRATION.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG THE **CHEST X-RAY FILM AND REPORT** FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH)
10. CHEST X-RAY DONE WITHIN **6 MONTHS PRIOR** TO REGISTRATION IS ACCEPTED.
11. THE UNIVERSITY RESERVES THE RIGHT TO REQUEST REPEAT OF FULL MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBTS IN THE MEDICAL REPORTS SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
12. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION:
  - (a) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
  - (b) IF THERE IS EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.



**SECTION 1**

**(PART B)** – Please tick ( ✓ ) in the relevant box.

Declaration of self and family illness. Explain in full if you or your immediate\* family has any of the following illnesses.

\* Immediate family refers to father, mother, brothers / sisters

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If “Yes” please state.
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Others:					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

-----  
Date

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Signature of candidate

**SECTION 2 - PHYSICAL EXAMINATION**

To be filled by examining doctor

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

2. GENERAL EXAMINATION			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEMIC EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

**SECTION 3 - INVESTIGATIONS**

<b>URINE TEST</b>		
<b>ITEM</b>	<b>DATE TAKEN</b>	<b>RESULT</b>
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMINES TYPE STIMULANT		

<b>BLOOD TEST</b>		
<b>ITEM</b>	<b>DATE TAKEN</b>	<b>RESULT</b>
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / TPHA		
e. MALARIAL PARASITE		

<b>CHEST X-RAY INFORMATION</b>	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

**SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR**

Please tick (√) in the appropriate box

I certify that I have on this date ..... examined

Mr / Ms .....Passport No. ....

and found him / her :-

IN GOOD HEALTH

HAVING THE FOLLOWING MEDICAL COMPLICATION(S) (Please State)

.....  
.....  
.....

UNDERGOING TREATMENT FOR: (Please State)

.....  
.....  
.....

Date : \_\_\_\_\_

Signature of Doctor : \_\_\_\_\_

Name of Doctor : \_\_\_\_\_

Qualification : \_\_\_\_\_

Hospital / Clinic

Registration Number : \_\_\_\_\_

Official stamp : \_\_\_\_\_

Remarks By University: