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.
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.

<table>
<thead>
<tr>
<th>Disease or Injury</th>
<th>Date</th>
<th>Duration</th>
<th>Name &amp; Address of Doctor or Hospital</th>
</tr>
</thead>
</table>

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:
   I …………………………………………………………………….declare 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:………………………….

Address/Stamp:…………………………

Date:……………………………………
FRESH STUDENTS’ ORAL SCREENING FORM

Name: ……………………………………………………………………………… Sex: …… Age: ………

Programme: ……………………………………………………………… Registration No: ……………

Part B – Dental Surgeon’s Findings

Teeth Present Decayed Teeth

Filled Teeth Missing Teeth

Other Conditions Present

1) ………………………………………………………………………………………………………
2) ………………………………………………………………………………………………………

Dental Surgeon’s Remarks

……………………………………………………………………………………………………………
……………………………………………………………………………………………………………

Signature …………………………… Date: ………………………
# EYE SCREENING FORM

<table>
<thead>
<tr>
<th>Surname:</th>
<th>Index No:</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name(s):</td>
<td>Programme of Study:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Sex: M ☐ F ☐ Phone No:</td>
</tr>
<tr>
<td>Father's academic qualification:</td>
<td>Father's Occupation:</td>
</tr>
<tr>
<td>Mother's academic qualification:</td>
<td>Mother's Occupation:</td>
</tr>
</tbody>
</table>

| Town of current residence: | Region of current residence: |
| Hometown: | Region of origin/Hometown: |

**Do you currently wear spectacles?**
- Yes ☐
- No ☐

**Have you ever been prescribed spectacles to wear?**
- Yes ☐
- No ☐

**When was the last time you had an eye test?**
- Less than six months ago ☐
- Within the past 6 to 12 months ☐
- Within the past one to two years ☐
- More than 2 years ago ☐
- Never/Cannot remember ☐

**Please indicate if any of these members of your nuclear family wear spectacles?**
- Father ☐
- Mother ☐
- Sibling ☐
- NONE ☐

**Please tick if you have any of the following conditions**
- Asthma ☐
- Diabetes ☐
- Hypertension ☐
- Sickle cell disease ☐
- NONE ☐

**Have you heard of an eye condition called glaucoma?**
- Yes ☐
- No ☐

**If yes, where did you hear it from?**
- Tick as many as apply
  - A family relative ☐
  - A general healthcare worker ☐
  - A friend ☐
  - An eye care professional ☐
  - Internet/social media ☐
  - TV/Radio or other mass media ☐

**Please indicate if any of these relatives of yours has glaucoma.**
- Father ☐
- Mother ☐
- Sibling ☐
- Uncle ☐
- Aunt ☐
- Grandfather ☐
- Grandmother ☐
- NONE ☐

**On an average day, how many hours do you spend using the following electronic devices?** Choose “Not applicable” if you do not use a listed device

<table>
<thead>
<tr>
<th></th>
<th>&lt; 2 hours</th>
<th>2 – 6 hours</th>
<th>6 – 10 hours</th>
<th>&gt; 10 hours</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal computer/Laptop</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smartphone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tablet/I-pad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Television</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please indicate)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**On an average day, how many hours do you spend on your electronic devices doing any of the following activities?**

<table>
<thead>
<tr>
<th></th>
<th>&lt; 2 hours</th>
<th>2 – 6 hours</th>
<th>6 – 10 hours</th>
<th>&gt; 10 hours</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online learning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reading the news or magazines</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social media (including video calls)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching videos or playing games</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*PLEASE TURN OVER PAGE*
### How OFTEN do you experience the following eye related symptoms?

**Rate the frequency on the scale of 0 (= never) to 4 (=always)**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Photophobia (high sensitivity to sunlight)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tired or strained eye</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itching</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Redness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grittiness or sandy sensation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred vision during near work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing lines when reading</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### How SEVERE are these eye related symptoms if you experience them?

**Rate the severity on the scale of 0 (= never) to 4 (= always)**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td></td>
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<tr>
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<tr>
<td>Itching</td>
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</tr>
<tr>
<td>Missing lines when reading</td>
<td></td>
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</tr>
</tbody>
</table>

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**FOR CLINICAL USE ONLY**

- **Student’s Surname:**
- **Index No:**
- **First Name(s):**
- **Date of Birth:**
- **Sex: M ☐ F ☐**

<table>
<thead>
<tr>
<th></th>
<th>UNAIDED</th>
<th>+1.00</th>
<th>WITH SPECTACLE RX / CONTACT LENSES</th>
<th>VA</th>
<th>HABITUAL AOA</th>
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<tbody>
<tr>
<td></td>
<td>@6M</td>
<td>@0.4M</td>
<td>PH</td>
<td>SPH</td>
<td>CYL</td>
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<tr>
<td>OD</td>
<td></td>
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<td></td>
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<tr>
<td>OS</td>
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<td></td>
</tr>
<tr>
<td>OU</td>
<td></td>
<td>DATE OBTAINED</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**NPC**

- **PHORIA TROPIA**
  - **OD:**
  - **OS:**

---

**COVER TEST**

- **OCULAR MOTILITY**
  - **OD:**
  - **OS:**

---

**PUPILLARY REFLEX**

- **DIRECT CONSENSUAL RAPD+**
  - **OD:**
  - **OS:**

---

**CONFRONTATION**

- **OD:**
- **OS:**

---

**EXTERNALS**

- **OD:**
- **OS:**

---

**INTERNALS**

- **(E/CD/D/LC/FR)**
  - **OD:**
  - **OS:**

---

**OTHER FINDINGS:**

---

**DOCTOR’S REPORT**

- **REFERRED ☐ NOT REFERRED ☐**

---

**REASON FOR REFERRAL/Dx:**

---

**INTERVENTION (IF GIVEN):**

---

**SIGNATURE/STAMP**

---

**DATE OF EXAMINATION**
Name: ....................................................................................... Age: ..........................................  
Registration No:.................................................................Date:..............................................  

FINDINGS  
VISUALS ACUITY  
Right Eye........................................................................... Left Eye...........................................................................  
EXTERNAL EXAMS  
Right Eye.......................................................................................................................  
Left Eye.......................................................................................................................  
INRENAAL 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
NAME OF STUDENT:……………………………………………………SEX………………AGE………………
REG No.: ………………………HALL OF AFFILIATION: …………………………………………………
PROGRAMME: ………………………………………………………………………………………………………
BRIEF HISTORY: ………………………………………………………………………………………………………

MEDICAL EXAMS

…………………………………………………………………………………………………………………………
…………………………………………………………………………………………………………………………

CHEST

X’Ray Required: ………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………

Date: ………………………………………… UHS

Senior Medical Officer
UNIVERSITY OF CAPE COAST
DIRECTORATE OF UNIVERSITY HEALTH SERVICES (DUHS)
LABORATORY REPORT

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Specimen</th>
<th>Examination</th>
<th>Result</th>
<th>Signed</th>
<th>Lab. No.</th>
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<tbody>
<tr>
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<td>HB</td>
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<tr>
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<td></td>
<td>SICKLING</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>HEPATITIS B</td>
<td></td>
<td></td>
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<tr>
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<td>HEPATITIS C</td>
<td></td>
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<tr>
<td></td>
<td>URINE</td>
<td>RIE</td>
<td>PROTEIN:</td>
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<td>DEPOSIT:</td>
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