

Checklist of health care Requirements for medical trainees

Student's name: Student ID.....

KKUH File Number:

Wt : Ht : BMI : BP :

System \ Finding	Vision	Hearing	C.V.S.	R.S.	Abdomen	C.N.S. (Power, Tremor Ataxia)
Normal						
Abnormal						

Comments:
.....

Blood Group

CBC: Normal Abnormal

Serology Screening	Positive	Negative	Comments
Hepatitis B (HBSAG)			
Hepatitis B (Antibody Level)			
Hepatitis C (HCV)			
HIV Screening			
Varicella Antibody (If negative a vaccination is required)			
Tuberculin screening test			

Chest X-Ray Result :

Vaccination:

Meningitis Vaccine: Yes No

Hepatitis B Vaccine: First Dose / Second / Third

Results: Yes NO

Influenza vaccine: Yes NO

Varicella zoster vaccine (if negative AB) Yes No

Supervisor Physician:

Name:

Signature:

Personal Information:

Full Name:

Sex: Male Female

University Number:

Phone Number:

Date of birth:

File Number:

National ID:

Medical History:

Please answer to all of the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Do you suffer from psychiatric or nervous disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you visit psychiatrist? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you take any psychiatric or nervous medicine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you a smoker? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any chronic disease such as | | |
| a. Cardiac disease or arteries | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |



كلية الأمير سلطان بن عبدالعزيز
للخدمات الطبية الطارئة

6. Do you take any medication for any disease?

If you are taking what is medication?

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I hereby declare that the information filled above is correct.

Student Name:

Signature: