DIRECTORATE OF HEALTH SERVICES
UMARU MUSA YARÁDUA UNIVERSITY, KATSINA
MEDICAL EXAMINATION FORM

Name of Student…….Age……
Faculty……Department……..Reg No…….

Gender,,Marital Status……Address……...

……..

Nationality……..State……

PATHOLOGY TESTS

S/N	REQUEST	RESULT
1.	Blood Group	
2.	Hb Genotype	
3.	PCV	
4.	Hepatitis	
5.	HIV	
6.	TB	
7.	Typhoid	

OTHER INFORMATION (on interview)

S/N	DISEASE	-VE	+VE
1.	STD's		
2.	Asthma		
3.	Heart Disease		
4.	Diabetes		
5.	Arthritis		
6.	Cancer		
7.	Leprosy		
8.	Any other disease that requires medical attention (specify)		

TEST CARRIED BY:

Name:…….Signature……Date…….

ENDORSEMENT:

Medical Director……Signature……Date…….