SWAMI VIPULANANDA INSTITUTE OF AESTHETIC STUDIES, EASTERN UNIVERSITY, SRI LANKA

STUDENTS HEALTH SERVICE - HEALTH HISTORY FORM

Academic Year 2020/2021

To:

Address:
Assistant Registrar,
Student Welfare,
Swami Vipulananda Institute of Aesthetic Studies,
Eastern University, Sri Lanka
Kallady, Batticaloa.

Student Registration No. :

2020/SVIAS/……/……

SWAMI VIPULANANDA INSTUTUTE OF AESTHETIC STUDIES, EASTERN UNIVERSITY, SRI LANKA

STUDENTS HEALTH SERVICE - HEALTH HISTORY FORM

This information is strictly for the use of University Health Service, and will not be released to anyone without your knowledge and consent.

Part - I of the form should be completed by the student and **Part - Il** should be completed by a Doctor registered with the medical council of Sri Lanka and it should be signed and stamped.

Part - I (To be filled by the student)

Full Name : …… .

Department : …… .

N.I.C. No. : …… .

Age : …… Sex : …… Sri Lankan / Foreign : ……..
(Sinhala/ Tamil/ Muslim/ Others)

Religion : …….. Civil Status : (Single/ Married)

Language Competence: (Sinhala/ Tamil/ English) : …….

Occupation of Father : ……..

Last School Attended : ……..

Home Address : ……..

District : ……..

Extra curricular activities during the school day :

Sports (Yes/ No) if yes indoor games/ outdoor games
Music (Yes/ No) Dancing (Yes/ No) Arts (Yes/ No)
Reli1gious Work (Yes/ No) Leadership (Yes/ No)

Person to notify in case of emergency :

Name : ……..……

Address : ……..……

Telephone No. : Land Phone No. : …… Mobile No. : ……...

Relationship : ……..……

Family Medical History

Relationship	ALIVE		Dead/ Age at Death	Cause of Death
	Age	State of Health if ill, mention the illness		
Father				
Mother				
Brother/ Sister				
Brother/ Sister				
Brother/ Sister				

Part- II O(for use of Medical Officer)

To be completed by a qualified doctor

Height	**Weight**	**Circumference of Chest**		**Abdominal Measurement**		**Posture**	**Use one ok mark to indicate the Following**
		Full Inspiration	Full Expiration	At Naval	Al lilac crest		Skin
Cardio Vascular System Pulse BP Heart		Respiratory System Lungs	Nervous System Are traces of paralysis, convulsion Insanity observable? ..... Are Knee Jerks normal?				Breast Thyroid
Digestive System Teeth- Decayed ..... Missing ..... Dentures ..... Gingivitis		Vision Vision acuity : L R Without glass .... With glass .... Colour Vision Red ..... Green					
Use check mark (✓) to indicate normal Varicose vein Hernia Hydrocele/Varicose Hemorrhoid		Speech : Hearing :		Clinical Test Hb% ..... Blood Group ..... Chest X- Ray (if indicated) Urine: Albumin ..... Sugar		Scars from operations/injuries	

Does the student NEED REFERAL to a specialist regarding any medical condition/ if so what is the condition?.....
.....
.....

I certify that I have carried out a full medical examination and that may opinion is based on the result of my examination and on the medical history or the applicant of Mr./Mrs./Miss .....is fit/not fit for studies is Swamy Vipulananda Institute of Aesthetic Studies, Eastern University, Sri Lanka for the following reasons:

Date : .....

.....
Signature of medical officer

Hospital :.....

FOR USE OF UNIVERSITY MEDICAL OFFICER

TYPE OF DEFECTS

Ocular
Dental
ENT
Surgical
Orthopedic
Medical
Dermatological
Psychological
Social Economic

ACTION AKEN: Referred to consultant forthwith/postponed till convenient
Advised and treated at Health centre.

Student Medical History:

Have you suffered from any of the following:

Infectious diseases	:	Mumps (Yes/No) Measles (Yes/No), Polio(Yes/No), Rubella (Yes/No), Infective Hepatitis (Yes/No), Whooping Cough (Yes/No), Chicken Pox (Yes/No), Tetanus (Yes/No), Diphtheria (Yes/No), Sexually transmitted disease (Yes/No) Others (specify) .....
Worm Infestation	:	Filarial (Yes/No), Others (specify) .....
Tropical Diseases	:	Malaria (Yes/No), Amoebic Dysentery (Yes/No), Dengue (Yes/No), Bacillary Dysentery (Yes/No), Others (specify) .....
Respiratory System	:	Frequent Colds (Yes/No), Hay Fever (Yes/No), Asthma (Yes/No), Pneumonia (Yes/No), T.B. Others (specify) .....
Circulatory System	:	Heart Disease (Yes/No), High Blood Pressure (Yes/No)
Nervous System	:	Epilepsy (Yes/No), Migraine (Yes/No), Nervous breakdown (Yes/No), other (specify) .....
ENT	:	Ear Infections (Yes/No)
EYE	:	Short Sight (Yes/No), Long Sight (Yes/No)
Surgical	:	Fractures(Yes/No) Operations(Yes/No)
Immunizations	:	Have you been vaccinated against Diphtheria, Tetanus, Whooping Cough, Polio, Typhoid, T.B (B.C.G) (Yes/No)
Mental Health	:	Have you any stress related problem? (Yes/no), Depression (Yes/No), Exam anxiety (Yes/No), Suicidal attempt (Yes/No)
Menstrual history	:	Period-regular/irregular flow-slight/normal/excessive pain (Yes/No)
Misc	:	High Blood Pressure (yes/no), Diabetic (Yes/No), Alcohol/Drugs (Yes/No), Tobacco/Cigarette (Yes/No) Allergies (specify) .....
Disability	:	Do you believe that you have a disability that any way requires you to receive special consideration from the University. If so please indicate the type of disability and give a brief description below: ....

I certify that the information furnished by me are true and accurate.

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