KEPERLUAN PEMERIKSAAN KESIHATAN UNTUK PELAJAR BAHARU
RANCANGAN PERSEDIAAN KHAS JEPUN (RPKJ)

- Pemeriksaan kesihatan adalah **WAJIB** bagi semua pelajar baharu.
- Pemeriksaan kesihatan boleh dilakukan di mana-mana Hospital/Klinik Kerajaan atau Swasta.
- Kesemua pelajar baharu perlu memenuhi keperluan Laporan Pemeriksaan Perubatan dengan mengikuti langkah-langkah berikut: -

    (a) Memuat turun Laporan Pemeriksaan Perubatan (Borang PD1)
    (b) Menghantar Laporan Pemeriksaan Perubatan ke kaunter penyerahan pada hari pendaftaran semester 1 sesi 2025/2026
    (c) Tarikh akhir penghantaran adalah selewat-lewatnya pada **satu (1) bulan atau 30 hari daripada tarikh pendaftaran Semester I sesi 2025/2026**
    (d) **Kegagalan pelajar** membuat pemeriksaan kesihatan akan menyebabkan pelajar **tidak layak mendapatkan faedah** di bawah **Skim Perkhidmatan Kesihatan Pelajar Universiti Malaya** antaranya rawatan di Klinik Universiti Malaya dan permohonan Surat Jaminan

- Sebarang maklumbalas atau pertanyaan lanjut berkenaan perkara ini saudara/saudari boleh menghubungi Klinik Universiti Malaya seperti butiran berikut: -

Klinik Universiti Malaya
Bangunan Siswarama
Fakulti Sastera dan Sains Sosial
Universiti Malaya
50603 Kuala Lumpur

Talian: **03-79676445** atau **03-79676444**
Emel**:** laporankesihatan@um.edu.my

FORM PD1

UNIVERSITI MALAYA

LAPORAN PEMERIKSAAN PERUBATAN
MEDICAL EXAMINATION REPORT

Gambar ukuran paspot (*Passport size photo*)

SILA ISI MENGGUNAKAN HURUF BESAR
(PLEASE USE CAPITAL LETTERS)

SEKSYEN 1 – Untuk Diisi Oleh Calon
***(SECTION 1** (To Be Completed By Candidate))*

BAHAGIAN A
(PART A)

NAMA PENUH / *FULL NAME*

KEWARGANEGARAAN / *NATIONALITY*

NO. KAD PENGENALAN/NO. PASSPORT / *IDENTITY CARD NO. / PASSPORT NO.*

NO. TELEFON / *CONTACT NO.*

TARIKH LAHIR / *DATE OF BIRTH*
D D M M Y Y

UMUR / *AGE*

JANTINA / *GENDER*
L/ M
P/ F

STATUS PERKAHWINAN / *MARITAL STATUS*
BUJANG *SINGLE*
KAHWIN /*MARRIED*

FAKULTI / *FACULTY*

NO. MATRIK / *MATRIC NO./*

NAMA SAUDARA TERDEKAT / PENJAGA / *NEXT OF KIN'S / GUARDIAN'S NAME*

ALAMAT SAUDARA TERDEKAT / *NEXT OF KIN'S ADDRESS*

NO. TELEFON SAUDARA TERDEKAT / *NEXT OF KIN'S CONTACT NUMBER* (UNTUK KECEMASAN/*FOR EMERGENCY)*

HUBUNGAN / *RELATIONSHIP*

BAHAGIAN B - Sila tandakan (√) dalam kotak yang berkenaan
***(PART B** - Please tick (√) in the relevant box.)*

Pengisytiharan tahap kesihatan diri sendiri *(Declaration of self illness).*

1. Adakah anda mengidap sebarang penyakit?
   Do you have any medical illness?

   ☐ Ya, nyatakan / *Yes, please state* ☐ Tidak / *No*

   _____

   _____

   _____

2. Adakah anda mengambil sebarang ubat untuk penyakit yang dinyatakan di atas?
   Are you currently taking any medication for the illness stated above?

   ☐ Ya, nyatakan / *Yes, please state* ☐ Tidak / *No*

   _____

   _____

   _____

3. Adakah anda pernah menjalani sebarang pembedahan?
   Have you had any surgery before?

   ☐ Ya, nyatakan / *Yes, please state* ☐ Tidak / *No*

   _____

4. Adakah anda mempunyai sebarang kecacatan?
   Do you have any disability?

   ☐ Ya, nyatakan / *Yes, please state* ☐ Tidak / *No*

   _____

5. Adakah anda mempunyai masalah kesihatan mental?
   Do you have any problem with mental illness?

   ☐ Ya, nyatakan / *Yes, please state* ☐ Tidak / *No*

   _____

6. Maklumat tentang tabiat merokok.
   Information regarding smoking habit.

   ☐ Perokok / Smoker ☐ Tidak merokok / Non smoker

   ☐ Bilangan rokok/hari / *Number of cigarette/day*

   ☐ Telah berhenti merokok / *Ex-smoker*

   Bila berhenti / *When do you quit?*
   _____(Tahun / *Year*)

BAHAGIAN C - Sila tandakan (√) dalam kotak yang berkenaan
***(PART C** - Please tick (√) in the relevant box.)*

SEJARAH IMUNISASI ***IMMUNISATION HISTORY***	**TARIKH VAKSINASI** ***DATE OF VACCINATION***					
BCG						
Pertussis						
Poliovirus						
Diphtheria						
Tetanus						
Mumps						
Rubella						
Measles						
Hepatitis B						
Varicella (Chicken Pox)						
Meningococcal ACWY						
COVID-19 Vaccine						

**any other vaccines will be added as determined by University Malaya from time to time*

☐ Saya dengan ini mengesahkan bahawa maklumat di atas adalah benar. Saya sedia maklum bahawa permohonan saya akan ditolak sekiranya maklumat yang diberikan adalah tidak benar. Saya dengan ini memberi keizinan agar laporan perubatan ini diserahkan kepada pihak universiti.
(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. I hereby give my consent for this medical report to be submitted to the university.)

....
Tarikh / *Date* Tandatangan calon / *Signature of candidate*

Name: ……

IC No: ……

SECTION 2 - PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT

HEIGHT :_____m

WEIGHT :_____kg

BMI :_____kg/m^2

BLOOD PRESSURE :_____mmHg

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 fundus copy)			
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			

Name: …….

IC No: …….

SECTION 3 - INVESTIGATIONS

Part 1A: (FOR ALL STUDENT)

URINE TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. ALBUMIN		
b. SUGAR		

Part 1B: Other Relevant Investigation (if applicable)

- Chest x-ray, blood test, and urine for drugs is not mandatory. However indicated if examining doctor's request, all reports must be enclosed.

1. Do you have any history of the following signs for the last two (2) weeks?

	√ or x
Prolonged cough	
Persistent fever	
Lack of appetite	
Weight loss	
Sweating at night	
Bloody cough	

2. Have your family/co-workers/schoolmates ever had TB (dry cough)?
3. High-risk groups that need to be screened for TB:

	√ or x
PLHIV	
Chronic renal failure on dialysis	
Rheumatoid Arthritis Patient on anti-TNF	
COPD	
Prison/detention centre detainees	
Diabetes	
Smoking	
Elderly	
Methadone and substance abuser	

Note;
Question 1 – If any of the symptoms ticked, perform AFB sputum examination and chest x-ray for screening and diagnosis of TB.
Question 2 – IF yes should consult/do TB contact screening.
Question 3 – If so should consult/perform TB high risk screening.

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT*	

***SILA LAMPIRKAN LAPORAN ASAL KEPUTUSAN UJIAN.**
****PLEASE ATTACH ORIGINAL TEST RESULT*.**

Name: …….

IC No: …….

Part 2: (FOR INTERNATIONAL STUDENT ONLY)

CHEST X-RAY INFORMATION		
CHEST X-RAY NO.		
DATE TAKEN		
PLACE TAKEN		
REPORT*		
URINE FOR DRUGS		
ITEM	**DATE TAKEN**	**RESULT**
a. MORPHINE		
b. CANNABIS		
c. AMPHETAMINES TYPE STIMULANT		
BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS Bs ANTIBODY		
c. HEPATITIS C		
d. VDRL / TPHA		
e. HIV		
f. MALARIAL PARASITE (BFMP)		

SILA LAMPIRKAN LAPORAN ASAL KEPUTUSAN UJIAN.
***PLEASE ATTACH ORIGINAL TEST RESULT*.**

Name: …….

IC No: …….

Part 3: (FOR MEDICAL/DENTAL/PHARMACY STUDENT ONLY)

CHEST X-RAY INFORMATION		
CHEST X-RAY NO.		
DATE TAKEN		
PLACE TAKEN		
REPORT*		
BLOOD TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS Bs ANTIBODY		
c. HIV		
MANTOUX TEST		
ITEM	**DATE TAKEN**	**RESULT**
a. MANTOUX TEST (TUBERCULOSIS SCREENING)		

SILA LAMPIRKAN LAPORAN ASAL KEPUTUSAN UJIAN.
***PLEASE ATTACH ORIGINAL TEST RESULT*.**

Name: …….

IC No: …….

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

I hereby certify that I have examined_____with ID No. / Passport No._____on this date_____and found him/her:

☐ IN GOOD HEALTH

☐ HAS MEDICAL PROBLEM (Please State)

_____

_____

_____

☐ IS UNDERGOING TREATMENT FOR: (Please State)

_____

_____

_____

Date:_____

Signature of Doctor: _____

Name of Doctor: _____

Qualification &: _____

Official stamp of Clinic

Remarks by University Official: