ชื่อทุน .....

MEDICAL CERTIFICATE

ติดรูปถ่าย

Place of Examination : .....

Date of Examination : .....

I Certify that the above I examined

Name : ..... Age .....Sex ☐ M ☐ F

Date of Birth : .....Marital Status ☐ M ☐ S

Home Address : .....

.....

Tel. : ..... E-Mail : .....

I examined specifically for evidence of any of the following items:

A. MEDICAL HISTORY

Have you ever in your life, including childhood, had any of the following :-

Yes	No		Detailed Information
.....	.....	Asthma	.....
.....	.....	Hypertension	.....
.....	.....	Hemoptysis	.....
.....	.....	Heart Diseases	.....
.....	.....	Diabetes Mellitus	.....
.....	.....	Jaundice	.....
.....	.....	Epilepsy	.....
.....	.....	Edema	.....
.....	.....	Otorrhea	.....
.....	.....	Hernia	.....
.....	.....	Hemorrhoid	.....
.....	.....	Accidents	.....
.....	.....	Fracture	.....
.....	.....	Surgical Operation	.....
.....	.....	Alcohol Consumption	.....

Your L.M.P. .....

I certify that the above answers are true and complete, I am aware that any falsification or omission of fact result in my immediate discharge from the scholarship program.

.....

(.....) Examinee

B. PHYSICAL EXAMINATION

(to be filled in by physician)

HEIGHT ..... cm

WEIGHT ..... kg

BLOOD PRESSURE ...../..... mmHg

PULSE RATE ..... per min.

	Normal	Abnormal	Detected Abnormalities
GENERAL APPEARANCE	_____	_____	.....
SKIN	_____	_____	.....
SCALP	_____	_____	.....
LYMPH NODES	_____	_____	.....
EYES			
VISION -WITH GLASSES			
RIGHT EYE	_____	_____	.....
LEFT EYE	_____	_____	.....
COLOR BLINDNESS	_____	_____	.....
TRACHOMA	_____	_____	.....
EARS	_____	_____	.....
OTOSCOPIC EXAM.	_____	_____	.....
NOSE	_____	_____	.....
PHARYNX & TONSILS	_____	_____	.....
TEETH	_____	_____	.....
THYROID GLAND	_____	_____	.....
LUNGS	_____	_____	.....
HEART	_____	_____	.....
ABDOMEN	_____	_____	.....
LIVER/SPLEEN	_____	_____	.....
HERNIA	_____	_____	.....
EXTERNAL GENITALIA	_____	_____	.....
ULCER	_____	_____	.....
ANUS	_____	_____	.....
SPINE	_____	_____	.....
LOCOMOTOR/SENSATION	_____	_____	.....
REFLEXES	_____	_____	.....
OTHERS	.....		

C. LABORATORY EXAMINATION

1. BLOOD EXAMINATION

BLOOD GROUP .....

HEMOGLOBIN ..... GM%

HEMATOCRIT ..... %

BLOOD FILM

MARARIA _____ NEGATIVE _____ POSITIVE

MICROFILARIA _____ NEGATIVE _____ POSITIVE

(For Clinical Suspected Case Only)

WBC ..... % CELLS/cu.mm.

PMN ..... %

LYMPH ..... %

MONO ..... %

EOS ..... %

BASO ..... %

OTHERS .... %

2. SEROLOGICAL TEST

VDRL _____ NEGATIVE _____ POSITIVE

3. URINE/URETHRAL EXAMINATION

URINALYSIS

COLOR .....

SP. GRAVITY .....

pH .....

SUGAR .....

ALBUMIN .....

BLOOD .....

BACTERIA .....

OTHERS .....

MICROSCOPIC EXAM. .....

URINE PREGNANCY TEST

(For Female Only) _____ NEGATIVE _____ POSITIVE

URINE EMIT TEST (Opiate, Amphetamine, Marijuana)

_____ NEGATIVE _____ POSITIVE

URETHRAL DISCHARGE SWAB MICROSCOPIC EXAM.

(For Clinical Suspected Case Only)

FINDINGS .....

4. BIOCHEMICAL ANALYSIS

CREATININE .....

FBS .....

CHOLESTEROL .....

TRIGLYCERIDE .....

5. STOOL EXAMINATION

PARASITES

E. HISTOLYTICA _____ NEGATIVE _____ POSITIVE

OTHERS .....

6. CHEST X-RAY

FINDINGS .....

.....

7. OTHER EXAMINATION

(SUGGESTED BY CLINICAL EXAM PHYSICIAN)

....

....

....

Place of Examination : .....

Date of Examination : .....

Examiner's Name : .....

Examinee's Name : .....

I hereby certify that the examinee is

_____ physically ready for study abroad.

_____ physically <u>not</u> ready for study abroad.

....

SIGNATURE OF MEDICAL COMMITTEE | TITLE | DATE

ชื่อทุน .....

MENTAL HEALTH EXAMINATION

ติดรูปถ่าย

Place of Examination : .....

Date of Examination : .....

I Certify that the above date I examined

Name : ..... Age .....Sex ☐ M ☐ F

Date of Birth : .....Marital Status ☐ M ☐ S

Home Address : .....

.....

Tel. : ..... E-Mail : .....

Summary of Results :

I hereby certify that the examinee has no current evidence of psychiatric disturbance that interferes with the ability to study.

(Signature) .....

(.....)

Psychologist

(Date) .....

(Affiliation) .....