PROTESTANT UNIVERSITY OF RWANDA

Fides et Scientia Ω Rwanda

Application for MEQUAM
Health Certificate

(for completion by doctor of medicine only)

1. (Please type or complete in capital letters)

Surname: Date of birth

First name:

Address:

1. Height: cm

2. Weight: kg

3. Sex: □ male □ female

4.1 Blood pressure (mm/Hg)
Lying:
Standing:

4.2 Pulse resting:
after 10 knee bends:
after 2 minutes:

4.3 Urine (fresh sample)
Protein: sugar: sediment:

5. Previous illnesses, operations and accidents? □ no □ yes

5.1 If yes, please specify. Treated when and by whom?
What medication and other remedies or treatments were prescribed?

6. Is the person currently receiving medical treatment or is such treatment planned? □ no □ yes

6.1 If yes, please provide brief details

7. Do you consider the heart, circulation and blood vessels to be healthy? □ no □ yes

7.1 If no, please provide brief details

8. Do you consider the respiratory organs to be healthy? □ no □ yes

8.1 If no, please provide brief details

9. Do you consider the limb function to be normal? □ no □ yes

9.1 If no, please provide brief details

10. Do you consider the skin to be healthy? □ no □ yes

10.1 If no, please provide brief details

11. Do you consider the abdominal organs (including the urinary and sexual organs) to be healthy? □ no □ yes

11.1 If no, please provide brief details

11.2 For women only: Is the woman pregnant? □ no □ yes

If yes, when is the expected date of delivery? _____

12. a) Do you consider the nervous system and sensual organs to be healthy? □ no □ yes

b) Is the mental/psychological behavior of the person unusual? □ no □ yes

12.1 If no, please provide brief details

13. Are you aware of any other abnormalities or medical afflictions e.g. hormone or metabolism disorders, allergies? □ no □ yes

13.1 If yes, please provide brief details

14. Are you aware of any other important medical findings (including results of blood tests e.g. for rheumatisms, allergies, hepatitis, AIDS) □ no □ yes

14.1 If yes, please provide brief details

15. State of teeth and jaw:

15.1 Do you consider the teeth to be healthy? □ no □ yes

15.2 If no, please provide name and address of dentist providing treatment

Date, place

Signature and stamp of medical doctor who completed this form