



HEALTH DECLARATION FORM

Name : _____ Matric no. : _____

Programme : _____ Intake : _____

Mobile No. : _____ Tel No. (House) : _____

Name and contact no. : _____

(In case of emergency)

Relationship : _____

Please indicate if you have ever suffered from or experienced or received treatment for the following diseases or conditions: (Please tick (✓) in the respective box)

	Yes	No		Yes	No
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bronchial Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Illness	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>

Others: _____

If YES, please specify.

Have you been hospitalized in the past 5 years? (If YES, please specify)

DECLARATION

I declare that the above information given by me is true and complete. I hereby authorize Universiti Islam Malaysia to verify information about me from whichever source you consider appropriate.

Signature

Date : _____