Evangelical University

CONFIDENTIAL MEDICAL REPORT

PART I TO BE FILLED IN BY APPLICANT BEFORE SEEING A DOCTOR

FAMILY NAME FIRST NAME(s) DATE OF BIRTH

ADDRESS

PAST MEDICAL HISTORY:

Have you had any of the following diseases in the past?

	NO	YES	IF YES GIVE DETAILS
TUBERCULOSIS			
LEPROSY			
ASTHMA			
HIGH BLOOD PRESSURE			
RHEUMATIC FEVER			
ANY ADMISSION TO HOSPITAL			
ANY OPERATIONS			

PRESENT MEDICAL HISTORY

Are you suffering at present from any of the following diseases?

	NO	YES	IF YES GIVE DETAILS
EYE TROUBLE			
EAR, NOSE OR THROAT TROUBLE			
CHEST TROUBLE			
HEART TROUBLE			
STOMACH TROUBLE			
TROUBLE WITH URINE SYSTEM			
BONE OR JOINT TROUBLE			
SKIN TROUBLE			
NERVOUS TROUBLE			
SEXUALLY TRANSMITTED DISEASE			
ALLERGIC TROUBLE			

Do you consider yourself healthy? If not, please state present complaint:

_____

_____

_____

Are you on any medications at the present time? Please give details - Name of medication, etc.

_____

_____

SIGNATURE: _____

PART II TO BE FILLED IN BY MEDICAL OFFICER

NAME: _____ DATE OF BIRTH: _____

WEIGHT: _____ HEIGHT: _____ BLOOD PRESSURE: _____

PLEASE CHECK IF NORMAL	REMARKS
GENERAL CONDITION _____ EYES _____ EARS, NOSE, THROAT _____ LUNGS & HEART _____ CARDIOVASCULAR _____ ABDOMEN _____ GENITO – URINARY _____ SKIN _____ BONES, JOINTS & NECK _____ CENTRAL NERVOUS SYSTEM _____ BREASTS IN FEMALE _____	

LABORATORY TEST Hb_____

URINE EXAMINATION_____

STOOL EXAMINATION_____ CHEST X-RAY (If indicated) _____

Is the applicant in your opinion medically fit to undertake a course at the University?

_____

PLACE & DATE_____SIGNATURE_____

ADDRESS_____

NAME & QUALIFICATIONS IN BLOCK LETTERS

_____
_____
_____
_____
_____