

Name: **Medical File #:**

Age: **Sex:** **Weight:** **Height:**

Any history of congenital / hereditary disorder? Yes No

If yes, please specify:

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Any significant past medical & surgical history? Yes No

If yes, please mention the details:

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Is there any diagnosed chronic condition/s? Yes No

If yes, please mention the details:

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Is there any pre existing medical condition/s? Yes No

If yes, please mention the details:

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Complete Assessment of Medical Examination:

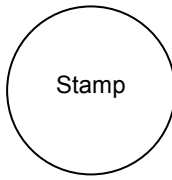
Blood pressure: _____ Pulse: _____

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I certify that the above information is a record of a careful examination; I hereby also declare that the statements and answers to the above questions are complete and true to the best of my knowledge & belief.

Physician Name

Signature



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Date: / /