Medical Examination Form

Name: ..... **Medical File No.:** .....

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

Any history of congenital/hereditary disorder? ☐ Yes ☐ No
If yes, please specify:

.....

.....

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 and belief.

Physician Name **Signature**

.....

Date: / /

Stamp