

Sinusitis: Y N _____ Difficulty in Hearing: Y N _____

-- METABOLIC --

Diabetes: Y N _____ Other: Y N _____

-- MEDICAL TREATMENT --

Received: Y N If Yes, Specify _____

Doctor

F.N.P

Signature

Date

-- SURGERY--

Have you ever had Surgery? (Major/Minor) _____

Comments

-- GYNAECOLOGICAL--

Dysmenorrhoea _____ L.M.P _____

Abnormal Bleeding? _____

-- DRUGS --

Do you take any medication regularly? Y N _____

Comments

-- IMMUNIZATION--

B.C.G. _____ D.P.T. _____ Measles _____

Rubella _____ Polio _____

-- EXAMINATION --

Height _____ Weight _____ T _____ P _____ R _____ B/P _____ Ears _____

Nasopharynx _____ Chests _____ Breasts _____

Abdomen _____ C.N.S. _____ Musculoskeletal _____ Other _____

REMARKS

PLACE STAMP HERE

Doctor's Signature

Date

**N.B. ABSENCE OF DOCTOR'S STAMP RENDERS MEDICAL REPORT
INVALID**