MEDICAL EXAMINATION

Name : _____ Age : _____

Sex : _____ Religion : _____

Father's Name : _____

Home Address : _____

Phone : _____ E-Mail : _____

Weight : _____ Height : _____

Vision : _____ Hearing : _____

1. Has the candidate suffered from any major illness in the past viz, sickle cell disease, congenital illness.

   _____

2. Has any one in his/her family have Tuberculosis, Diabetes, Heart Disease, Hypertension ?

   _____

3. What diseases has he/she had and treatment taken :

   Heart B.P. Lungs X-ray Report

   Abdomen Liver Spleen

4. Menstrual History : Regular/Irregular _____

5. Any problem related to :

   Nose Throat E.S.R.

   Skin Glands

6. LABORATARY :

   VDRL _____ HBsag _____ Hb _____ Sickle cell _____

   Total Blood Cell Count _____ RBC _____

7. Complete Urinalyses Complete Stool Examination

   a. Sugar Ova

   b. Albumin Cyst

   c. Microscopic Parasite

8. Vaccinations & Inoculation with Dates

   OPV DPT/DT Hepatitis B B.C.G Tetanus Toxide.

9. Has the candidate suffered from any major illness since birth ?

   Yes / No

   If yes, give a brief detail. _____

   _____

10. Does the candidate have

   - Chronic Headache - Backache

   - Abdominal Pain / Chest Pain / Palpitation

     Joint Pain

     Visual Disturbance - Bronchial Asthma

     Epilepsy

     Do you consider her/him fit for Nursing training of 4 years duration?

Doctor's Signature with Stamp

Date : _____ **& Registration No. :** _____