FORM M): MEDICAL EXAMINATION FORM

NAME: ……..……. **AGE**: …….. **SEX**: …….
SURNAME *MIDDLE* *FIRST*

Past Medical History

Diabetes Yes ☐ No ☐ Asthma Yes No ☐ ☐ PTB Yes ☐ ☐

No ☐ ☐ ☐ ☐

Hypertension Yes No Epilepsy Yes No

Previous Admission Yes ☐ No ☐ Previous Surgery Yes ☐ No ☐

If yes give details: ……...

…….

Family History

Diabetes Yes ☐ No ☐ Asthma Yes No ☐ No ☐ PTB Yes ☐ ☐

No ☐ ☐ ☐ ☐ ☐ ☐

Epilepsy Yes No Mental Illness Yes No Renal/Cardiac dxs Yes

No

If yes give details: ……...

…….

Vaccination

Complete KEPI schedule Yes ☐ No ☐

Yellow Fever Yes ☐ No ☐ Hepatitis B Yes ☐ No ☐ Typhoid Yes ☐ No ☐

Rebella Yes ☐ No ☐

Physical Findings

Height: ……. Weight: …….B/P: ……. Lymph nodes: ……..

Eyes Rt. ……... Lt:…….. Ears Rt.:…….. Lt.:……

Respiratory System: …….. … CXR (if necessary):……..

Cardiovascular System: ……..

…….

Per Abdomen: ……. Liver: …… Spleen: …….. Kidney Rt.:…….. Lt.:…….

Laboratory tests (if indicated) Urinalysis: …… Haemogram: ……. Blood: …….

Remarks: …….

…….

I hereby certify that I have today ……..examined the above mentioned person and to the best of my professional opinion he/she is medically fit/unfit for Employment or School or Training.

Name: Dr……Date: ……