

Medical History and Report

Name of Nominee Age

Country.....

***Physical Examination (To be filled in by physician)**

Present Status

Height Cms. Weightkgs. Blood Pressure mm.Hg. Pulse/min.

Vision RightLeft Eyes With glasses / Without glasses

a) Do you currently use any drugs for the treatment of a medical condition? (give name and dosage)

() No

() Yes : name of medication (.....), Quantity (.....)

b) Are you pregnant?

() No

() Yes : (..... months)

c) Are you allergic to any medication or food?

() No

() Yes : () Medication : () Food : () Other: _____

Laboratory Examinations

Blood groupBlood film for malariaHb gm%

WBC Cells/cu.mm.

Differential PMN % Lymp % Mono % Eos %

Baso % Band..... % Blast %

Urinalysis : Colour Sp. Gr pH Sugar

Alb BloodKetones Blie.....

Micro : WBC...../HPF.,RBC/HPF.,Epethelial...../HPF.

Casts...../HPD., Others

Stool examination for parasite & Ova

Chest X – Ray report

Urine pregnancy test

Check each item in appropriate column			
Item	Normal	Abnormal	Additional comment
General	<input type="checkbox"/>	<input type="checkbox"/>
Skin, Scalp	<input type="checkbox"/>	<input type="checkbox"/>
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Ears	<input type="checkbox"/>	<input type="checkbox"/>
Otoscopic Exam			
Nose	<input type="checkbox"/>	<input type="checkbox"/>
Pharynx & tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid gland	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Liver	<input type="checkbox"/>	<input type="checkbox"/>
Spleen	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Rectal exam.	<input type="checkbox"/>	<input type="checkbox"/>
Vertebrae	<input type="checkbox"/>	<input type="checkbox"/>
Locomotor	<input type="checkbox"/>	<input type="checkbox"/>
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>
Mental health status	<input type="checkbox"/>	<input type="checkbox"/>

Is the nominee able physically and mentally to carry on intensive study away from home?
.....

Is the nominee free from infectious diseases (such as tuberculosis, leprosy, syphilis and filariasis) and other conditions (such as psychosis and drug addiction) which could present risks for anyone during the fellowship period?
.....

Does the nominee have any condition or defect which might require treatment during the fellowship period?
.....

Full name and address of
Examining physician (printed)
.....
.....
.....
.....
.....

Physician signatureM.D.
(.....)
Date