

## Medical Forms

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### MEDICALS

General Information for medicals

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|  |                                      | Answer |
|--|--------------------------------------|--------|
|  | Do you have health problem(s)?       | No     |
|  | Are you currently on any medication? | No     |
|  | Are you allergic to any drugs?       | No     |

## Past medical history

|  |  | Answer |
|--|--|--------|
|  | Any history of surgical operation?               | No     |
|  | Have you been hospitalized in the past one year? | No     |

## Any past history of

|  | Any past history of:  | Answer |
|--|-----------------------|--------|
|  | Asthmatic attacks?    | No     |
|  | Epilepsy/Convulsions? | No     |
|  | Mental Illness?       | No     |
|  | Tuberculosis?         | No     |
|  | Drug Addiction?       | No     |
|  | Heart Disease?        | No     |
|  | Kidney Disease?       | No     |
|  | Diabetes Mellitus?    | No     |
|  | High Blood Pressure?  | No     |
|  | Bone Pains?           | No     |

## Any family history of:

|  |                 | Answer |
|--|-----------------|--------|
|  | Epilepsy?       | No     |
|  | Mental Illness? | No     |
|  |                 |        |

|  |                      |    |
|--|----------------------|----|
|  | Tuberculosis?        | No |
|  | Diabetes?            | No |
|  | High Blood Pressure? | No |
|  | Asthmatic?           | No |
|  | Heart Disease?       | No |

|  |                       |   |
|--|-----------------------|---|
|  |                       | <b>Answer</b>   |
|  | Family Doctor Details | <b>Name of the Doctor: Address of the Doctor: Doctor's Country:</b><br><br><b>Doctor's State:</b><br><br><b>Telephone of the Doctor: Email of the Doctor:</b> |

