

Medical Forms

MEDICALS

General Information for medicals

| | | 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 |

| | | |
|--|-----------------------|---|
| | | Answer |
| | Family Doctor Details | Name of the Doctor: Address of the Doctor: Doctor's Country: Doctor's State: Telephone of the Doctor: Email of the Doctor: |

