**HEALTH CHECK UP FORM**

**Name: Father’s Name:**

**Age: Sex: DOB Blood Group:**

**Address: Tel:**

**Family Physician (if any):**

**(Name, Address and Phone no.)**

**Identification Mark:**

**If yes, give details**

**History: Diabetes Yes/No**

**High Blood Pressure Yes/No**

**Heart disease Yes/No**

**Asthma/TB Yes/No**

**Refractive error Yes/No**

**Any other illness Yes /No**

**Examinations:**

**{A} GPE Pulse: /min. B.P.:**

Mental State: Height: cms

Pallor: Weight kgs

|  |  |  |
| --- | --- | --- |
| **Vision** | **With**  **Spectacles** | **Without**  **Spectacles** |
| Right Eye |  |  |
| Left Eye |  |  |

Lymph Nodes: **BMI:**

Skin:

Nails:

Dental

ENT:

**{B} Systemic Exam:**

Resp. System: **Investigations**

CVS: 1 - HB%

Abdomen: 2 - Urine (Routine Check)

Genitourinary: 3 - Any other:

CNS:

**Comments:**

**Certified medically: Fit /Unfit**

Signature with stamp

**Date of Examination** Name of the Doctor:

Qualifications:

Reg. No:

**F:/Sri Aurobindo Ashram/S.A.A/SAIVT/Master Files/Master file of VT/health Check up form.**