

MEDICAL AND TRAVEL HISTORY FORM

The submission of a completed *Medical and Travel History Form* is mandatory. The form should be completed and submitted before the residency.

MEDICAL AND TRAVEL HISTORY MUST BE COMPLETED BY THE APPLICANT IN ENGLISH AND SIGNED

CONTACT DETAILS

1. PGID: 000012020053	4. EMAIL ID: deepkamal_singh_ampba2021w@isb.edu
2. NAME: Deep Kamal Singh	5. MOBILE NUMBER: 9971003585
3. DATE OF BIRTH: 06 September 1983	6. BLOOD GROUP: AB +ve

7. Indicate YES or NO. YES answers MUST be explained in the space provided on page 2.

		YES	NO
a)	Have you ever had any significant or serious illness(es) or injuries? (State nature of problems & dates)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b)	Have you ever had any operations or been advised by a physician to have an operation? (Describe and give dates.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c)	Have you ever been a patient in a mental hospital or sanitarium or treated by a psychiatrist? (Give dates.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d)	Are you required to take long-term medication (list name/dose) for treatment of a medical condition or do you require the use of a medical device?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

8. Do you now have or have you ever had any of the conditions listed below? (Check YES or NO for each item.)

CHECK EACH ITEM	YES	NO		YES	NO
(a) Epilepsy, convulsions, fits.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(k) Joint disease or injury, swollen or painful joints	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(b) Eye disease, vision defect in one or both eyes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(l) Back pain, or spinal condition, use of back brace	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(c) Tooth or gum disease (periodontal disease).	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(m) Tropical diseases (malaria, bilharzia, amoebiasis, leprosy, filariasis, yaws etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(d) Asthma, emphysema, or other lung conditions symptoms.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(n) Depression, anxiety, attempted suicide or other psychological problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(e) Tuberculosis or exposure to tuberculosis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(o) Drug or narcotic habit such as marijuana, cocaine, heroin, LSD, or any derivatives.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(f) High/low blood pressure, heart disease.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(p) Bleeding disorder, blood disease, sickle cell anemia.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(g) Stomach, liver (hepatitis), gallbladder disease.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(q) Tumor, abnormal growth, cyst, or cancer.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(h) Hernia (rupture)/Genito-Urinary/Rectal Disorder.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(r) Skin disorder growths psoriasis.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(i) Kidney or bladder condition, stone or blood.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(s) Gynecological disease/abnormal menses.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
(j) Diabetes, sugar in the urine.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	(t) Hearing Impairment.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STUDENT'S SIGNATURE: _____ DATE: 12-Jan-2021



9. Have you now, or in the past 14 days, had any of the following flu-like symptoms? (Check YES or NO for each Item.)

		YES	NO
a)	Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b)	Breathlessness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c)	Cold/Cough	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d)	Sore throat	<input type="checkbox"/>	<input checked="" type="checkbox"/>

10. Are you allergic to any medicines? If yes, please list the names of these medicines below.

Yes

No

Questions 7/8/9 (Continued):

11. If you answered YES to any item in Question 7 or 8 or 9, please explain in detail (include dates of occurrence, treatment, and outcome):

12. Name two individuals who could be notified in case of emergency.

Name	Jaya Singh
Address	601, A2, Golf Link Residency, Sector 18 B Dwarka, New Delhi 110078
Telephone	9717733585
Relationship	Wife

Name	K B Singh
Address	601, A2, Golf Link Residency, Sector 18 B Dwarka, New Delhi 110078
Telephone	9718612358
Relationship	Father

STUDENT'S SIGNATURE: _____



DATE: 12-Jan-2021



13. Medical Insurance Details (should include Additional COVID Insurance)

Name of Insurance Provider: Mediassist TPA		
Policy Number: 10315989	Valid From: 1 April 2020	Valid To: 31 March 2021

14. Have you or any immediate family members travelled outside India since December 1st, 2020? If No, please mention NA.

NA

S.No.	Country & City	Date of arrival	Date of departure	Remarks (if any)

15. Have you or any immediate family members come into close contact with a confirmed case of Coronavirus in the last 14 days? ("Close contact" means being at a distance of less than three feet for more than 15 minutes.) If YES, please give more details in the below space (Name of City/Country where contact took place, when it took place etc). If No, please mention NA.

NA

Declaration

I certify that I have reviewed the foregoing information supplied by me, and that it is true and complete to the best of my knowledge. In the event of a serious illness or medical emergency during the study of course, I authorize to release of my medical information to the Hospital/Doctors.

I understand that if any of this information is found to be substantially inaccurate or incomplete, it may be grounds for termination of my admission.

STUDENT'S SIGNATURE: _____

DATE: **12-Jan-2021**