



REQUIRED ANAGKAZO BIBLE & MINISTRY TRAINING CENTRE (ABMTC)
MEDICAL ASSESSMENT FORM

DEAR DOCTOR,

THE ABMTC REQUIRES THE FOLLOWING FORM TO BE FILLED BY A LICENSED MEDICAL PRACTITIONER
FOR APPLICANTS WISHING TO ENROLL IN THIS INSTITUTION.

KINDLY INDICATE WHICH OF THE FOLLOWING TESTS HAVE BEEN DONE BY THE APPLICANT BY TICKING THE
RELEVANT BOX BELOW.

THANK YOU.

- | | |
|---|--------------------------|
| 1 FULL BLOOD COUNT | <input type="checkbox"/> |
| 2 URINE ROUTINE EXAMINATION | <input type="checkbox"/> |
| 3 STOOL ROUTINE EXAMINATION | <input type="checkbox"/> |
| 4 SICKLING TEST (FOR APPLICANTS OF AFRICAN DESCENT) | <input type="checkbox"/> |
| 5 HIV TEST | <input type="checkbox"/> |
| 6 CHEST X-RAY AND COMMENTS | <input type="checkbox"/> |
| 7 MENTAL HEALTH ASSESSMENT | <input type="checkbox"/> |

PERSONAL HISTORY OF APPLICANT

NAME:

ADDRESS:

AGE

TEL

SEX:

MEDICAL HISTORY OF APPLICANT1 ASTHMA ☐ YES ☐ NO2 EPILEPSY ☐ YES ☐ NO3 SICKLE CELL ☐ YES ☐ NO4 HISTORY OF MENTAL ILLNESS ☐ YES ☐ NO5 TB ☐ YES ☐ NO6 STOMACH ULCER ☐ YES ☐ NO7 HIV/AIDS ☐ YES ☐ NO8 DRUG ALLERGIES ☐ YES ☐ NO
If yes, Specify which drug(s).....10 DIABETES MELLITUS ☐ YES ☐ NO11 HYPERTENSION/OTHER CHRONIC HEART DISEASE ☐ YES ☐ NO12 GYNAECOLOGICAL DISEASE ☐ YES ☐ NO

Indicate other chronic diseases you suffer from.....

Are you on any regular medication? ☐ YES ☐ NO

If yes, Specify).....

Have you had any major surgeries? ☐ YES ☐ NO

If yes, Specify).....

PHYSICAL EXAMINATION

- CHEST
- CARDIOVASCULAR-PULSE.....BP.....MURMURS.....PRESENT ABSENT
- ABDOMEN
- CNS
- MUSCULOSKELETAL

LAB INVESTIGATIONS

- FULL BLOOD COUNT
- URINE ROUTINE EXAMINATION
- STOOL ROUTINE EXAMINATION
- SICKLING TEST
- CHEST X – RAY AND COMMENT
- HIV TEST

GENERAL COMMENTS

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NAME OF DOCTOR:.....

SIGNATURE:.....

CONTACT NUMBER:.....

EMAIL ADDRESS:.....

STAMP:

**KINDLY NOTE THAT RESULTS OF ALL LABORATORY TESTS AND CHEST X-RAYS SHOULD BE ATTACHED TO THIS FORM*