

## Medical History and Report

Name of Nominee ..... Age .....

Country.....

### **\*Physical Examination (To be filled in by physician)**

#### **Present Status**

Height ..... Cms. Weight .....kgs. Blood Pressure ..... mm.Hg. Pulse ...../min.

Vision Right .....Left ..... Eyes ..... With glasses / Without glasses

a) Do you currently use any drugs for the treatment of a medical condition? (give name and dosage)

No

Yes : name of medication ( ..... ), Quantity ( ..... )

b) Are you pregnant?

No

Yes : ( ..... months)

c) Are you allergic to any medication or food?

No

Yes : ( ) Medication : ( ) Food : ( ) Other: .....

#### **Laboratory Examinations**

Blood group .....Blood film for malaria .....Hb ..... gm%

WBC ..... Cells/cu.mm.

Differential PMN ..... % Lymp ..... % Mono ..... % Eos ..... %

Baso ..... % Band..... % Blast ..... %

Urinalysis : Colour ..... Sp. Gr ..... pH ..... Sugar .....

Alb ..... Blood .....Ketones ..... Blie.....

Micro : WBC...../HPF.,RBC ...../HPF.,Epethelial...../HPF.

Casts...../HPD., Others .....

Stool examination for parasite & Ova .....

Chest X – Ray report .....

Urine pregnancy test .....

**Check each item in appropriate column**

<b>Item</b>	<b>Normal</b>	<b>Abnormal</b>	<b>Additional comment</b>
General	<input type="checkbox"/>	<input type="checkbox"/>	.....
Skin, Scalp	<input type="checkbox"/>	<input type="checkbox"/>	.....
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Ears	<input type="checkbox"/>	<input type="checkbox"/>	.....
<b>Otoscopic Exam</b>			
Nose	<input type="checkbox"/>	<input type="checkbox"/>	.....
Pharynx & tonsils	<input type="checkbox"/>	<input type="checkbox"/>	.....
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	.....
Thyroid gland	<input type="checkbox"/>	<input type="checkbox"/>	.....
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	.....
Heart	<input type="checkbox"/>	<input type="checkbox"/>	.....
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	.....
Liver	<input type="checkbox"/>	<input type="checkbox"/>	.....
Spleen	<input type="checkbox"/>	<input type="checkbox"/>	.....
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	.....
External genitalia	<input type="checkbox"/>	<input type="checkbox"/>	.....
Rectal exam.	<input type="checkbox"/>	<input type="checkbox"/>	.....
Vertebrae	<input type="checkbox"/>	<input type="checkbox"/>	.....
Locomotor	<input type="checkbox"/>	<input type="checkbox"/>	.....
Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	.....
Mental health status	<input type="checkbox"/>	<input type="checkbox"/>	.....

Is the nominee able physically and mentally to carry on intensive study away from home?

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Is the nominee free from infectious diseases (such as tuberculosis, leprosy, syphilis and filariasis) and other conditions (such as psychosis and drug addiction) which could present risks for anyone during the fellowship period?

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Does the nominee have any condition or defect which might require treatment during the fellowship period?

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Full name and address of  
Examining physician (printed)

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.....  
.....

Physician signature .....M.D.

(.....)

Date .....