MEDICAL EXAMINATION REPORT

CANDIDATE'S STATEMENT & DECLARATION

The candidate must make the statement required below prior to his medical examination and must sign the Declaration appended thereto.

Photograph

1. State your name in full
   (In Block Letters): _____

   Father's Name : _____
2. State your Age & Birth Place : _____
3. (a) Have you ever had small-pox intermittent or any other fever, enlargement or suppuration of glands spitting of blood, asthma, heart disease, fainting attacks, Rheumatism, appendicitis ? : _____

   (b) Any other disease or accident requiring confinement to bed and medical or surgical treatment ? : _____
4. History of vaccination : _____
5. Have you or any of your near relations been affiliated with gout, asthma, fits, or Insanity? : _____
6. Have you suffered from a degree of deafness : _____
7. Have you suffered from any form of nervousness due to over work or any other cause :
8. Furnish the following particulars concerning your family (disease trend in family and premature death if any) : _____

Above statements are true and I have not suppressed any information.*

Candidate's Signature

Signed in my Presence- **Medical Superintendent**: Yes/ No?

*Note : -The candidate will be held responsible for the accuracy of above statements .
*For female candidate – **Chest radiograph to be done only after gynecology clearance.**

Report of the Medical Board on
Name of the Candidate:-

1. i) Height (Without shoes)_____cm Weight_____kg

   Chest circumference: After full inspiration_____cm full Expiration_____cm
   ii) Respiratory system _____
   iii) Circulatory system
   (a) Heart : Any organic lesions : _____

Rate Standing _____
ECG (pl attach) –date - Please mention abnormality if any

(b) Blood pressure___pulse rate_____ spO_2_____in room air

iv) Nervous system : _____
v) Loco Motor system : _____
vi) Skin: (any obvious disease)

Remarks

(Name, Signature & Medical Registration Number of Faculty of Medicine)

2. **Eyes** : (a) Any disease : Yes (mention)/No _____
   (b) Defect in colour vision : Normal/Abnormal (mention)
   (c) Field of vision : Normal/Abnormal (mention)
   (d) Visual acuity : _____

	Acuity of vision	**Without glass**	**With glass**
Near Vision	Right Eye Left Eye		
Distant Vision	Right Eye Left Eye		

Remarks

(Name, Signature & Medical Registration Number of Faculty Ophthalmology)

3. Ears Inspection_____Hearing_____Right Ear : _____

   Left Ear: _____

   Glands :_____Thyroid _____

   General condition of teeth and oral cavity _____

   Remarks:

(Name, Signature & Medical Registration Number of Faculty Otolaryngology)

4. Abdomen : Tenderness_____Hernia _____
   (a) Palpable: Liver_____Spleen_____Kidneys_____

   Any others _____

   Genito Urinary System: Hydrocele_____Varicocele_____
   (b) Hemorrhoids_____Fistula_____Varicose Vein_____
   (c) Lymphadenopathy (Palpable)_____

   Remarks:

(Name, Signature & Medical Registration Number of Faculty Surgery)

5. Gynecologic history and examination(for female candidates):

Status: Single/Married

Age at menarche: yrs

History of Polycystic ovarian syndrome(PCOS): yes/no

Last visit to gynaecologist and reason of visit: yes/no

Last whole abdominal ultrasound done and indication : yes/no

Past history of Tuberculosis/ intake of ATT: yes/no

Past history of gynaecologic surgery/ intake of chemotherapy: yes/no

Menstrual cycle:

Length: Duration of flow: Regularity:

Associated dysmenorrhoea: Last menstrual period(LMP):

Examination: 1) lymphadenopathy/ scars/ other deformities:

2) Breasts and axilla for any evidence of Mass/ abnormal discharge:

3) Abdomen examination

Remarks:

(Name, Signature & Medical Registration Number of Faculty, OBST & Gyn)

6. Haematology, Blood Sugar, Urine analysis report (To be attached)
Blood group and RH factor –(if known)

Remarks (Please mention if any major abnormalities)

(Name, Signature & Medical Registration Number of Faculty, Biochemistry)

7. Report of screening chest radiograph (no- date-)

(**Name, Signature & Medical Registration Number, Radio-diagnosis)**

8. Mention if there is anything in the health of the candidate likely to render him/her unfit?

Note: Record their finding under one of the following categories and strike out others.

(i) Fit

(ii) Unfit on the following reasons _____

(iii) Temporarily unfit on account of ……

Chairman, Medical Board/Medical Superintendent

Name:

Medical Registration No:

Post:

Name of the Institute:

Dated: _____

Special medical board opinion (if required): ……