MEDICAL FORM

CLASS : _____

Name in full : _____ Gender : Male / Female

Date of Birth : _____ Place of Birth : _____
Date Month Year

Religion : _____

Residential Address :_____

_____

City : _____ State: _____ Pincode : _____ Tel No. (Resi.) _____

Number of siblings ☐ : Name _____ Age _____

Name _____ Age _____

Number of members living at home ☐ : _____

and their relationship : _____

: _____

Vaccines given : (TICK whichever is applicable)

☐	B.C.G.	☐	MEASLES	☐	CHICKEN POX
☐	OPV. DPT	☐	HEPATITIS-A	☐	MMR
☐	1st BOOSTER	☐	HEPATITIS-B	☐	OTHERS
☐	2nd BOOSTER	☐	T.T		

1. Blood Group _____
2. Weight in Kg. _____
3. Height in Cm. _____
4. ENT* _____
5. Skin _____
6. Respiratory System _____
7. Chronic Illness (if any) _____

   _____

   _____
8. Surgery Details (if any) _____

   _____

   _____

Note : *(Please consult - ENT Physician / Surgeon)

HEALTH & MEDICAL HISTORY

1. Past significant illness :

2. Current health-related complaints or illness :

3. Treatment received for current ailment (if any) :

4. Date of last physical examination and result*

5. Name of the physician and contact number :

6. Significant health problems in the family of origin (parent, grandparents, siblings)

7. Sleep pattern :

8. Appetite level :

9. Current medication (if any) :

10. Drugs and non-drug allergies :

11. Daily diet habits :

* Please attach copy.

Doctor's Signature & Stamp