

Medical Examination Form

Name: _____ **Medical File No.:** _____

Age: _____ **Sex:** _____ **Weight:** _____ **Height:** _____

Any history of congenital/hereditary disorder? ☐ Yes ☐ No

If yes, please specify:

Any significant past medical & surgical history? ☐ Yes ☐ No

If yes, please mention the details:

Is there any diagnosed chronic condition(s)? ☐ Yes ☐ No

If yes, please mention the details:

Is there any pre-existing medical condition(s)? ☐ Yes ☐ No

If yes, please mention the details:

Complete Assessment of Medical Examination:

Blood Pressure: _____ **Pulse:** _____

I certify that the above information is a record of a careful examination; I hereby also declare that the statements and answers to the above questions are complete and true to the best of my knowledge and belief.

Physician Name

Signature

Date: _____

