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

Item	Normal	Abnormal	Additional comment
General	☐	☐	.....
Skin, Scalp	☐	☐	.....
Lymph nodes	☐	☐	.....
Eyes	☐	☐	.....
Ears	☐	☐	.....
Otoscopic Exam			
Nose	☐	☐	.....
Pharynx & tonsils	☐	☐	.....
Teeth	☐	☐	.....
Thyroid gland	☐	☐	.....
Lungs	☐	☐	.....
Heart	☐	☐	.....
Abdomen	☐	☐	.....
Liver	☐	☐	.....
Spleen	☐	☐	.....
Hernia	☐	☐	.....
External genitalia	☐	☐	.....
Rectal exam.	☐	☐	.....
Vertebrae	☐	☐	.....
Locomotor	☐	☐	.....
Reflexes	☐	☐	.....
Mental health status	☐	☐	.....

Is the nominee able physically and mentally to carry on intensive study away from home? .....
Is the nominee free from infectious diseases (such as tuberculosis, leprosy, syphillis and filariasis) and other conditions (such as psychosis and drug addiction) which could present risks for anyone during the fellowship period? .....
Does the nominee have any condition or defect which might require treatment during the fellowship period? .....
Full name and address of Examining physician (printed) .... Physician signature .....M.D. (.....) Date .....