# SAGANA TECHNICAL TRAINING INSTITUTE

**P.O. BOX 24-10230, SAGANA. Tel. 0728 956852**

## MEDICAL EXAMINATION FORM.

**1. PERSONAL HISTORY:**

Surname _____

Other names _____

Date of birth _____

Next of kin _____

Relationship _____

Address _____

Tel. No. _____

**2. SOCIAL HISTORY:** please indicate where appropriate

Are you on regular doctor's medication? Yes_____ No _____ which one_____

Do you have a history of mental illness? No _____ Yes _____ give details below

Do you suffer from any chronic illnesses? No_____ Yes____ if yes, which one: _____

Diabetes_____ hypertension_____ tuberculosis_____ hepatitis ____ sickle cell disease_____

Leukemia _____ Asthma_____Epilepsy _____ Other _____

Do you have a history of hospitalization? No _____ Yes_____ if yes, for how long _____

Have you had any of these symptoms for more than one week?

Fever_____ cold chills_____ diarrhoea & vomiting _____ other _____

Do you suffer from any allergies? Yes _____ No _____ if yes, which one _____

_____

**3. FAMILY HISTORY:**

Do any of your relatives suffer from?

High blood pressure_____ diabetes _____ heart disease_____ allergies _____ __

mental illnesses _____ epilepsy _____ other, please specify_____

**4. GENERAL EXAMINATION** {to be filled by your general medical practitioner}

General Appearance_____ Weight_____ height_____

Respiratory system: breath sounds _____ respiratory rate _____

Cardiovascular system: pulse _____/min BP _____mmhg

Heart sounds _____

Genital-urinary tract _____

Ear/nose/throat: _____

Skin: _____

Visual acuity: R/E _____ L/E: _____

Comments: _____

_____

**5. LABORATORY EXAMINATION** {please attach lab reports}

Haemogram _____ ESR _____VDRL _____ Blood group _____

Urinalysis _____Chest X-ray view _____pregnancy test _____ other _____

**6. FOR DOCTORS USE ONLY**: {official stamp should be included}

Doctor's name _____ Institution _____

Signature _____ Date of examination_____

Official Stamp_____

**7. PERSONAL DECLARATION**

I hereby consent to offer this information to any Medical authority as deemed necessary to effect quick treatment.

Student's name _____Signature_____Date_____