HEALTH CHECK UP REPORT

Name: ________________________________ Father's Name: ______________________________

Age: ___________ Sex: ________ Date of birth: _______________ Blood Group: ____________

Address: ____ Tel: __________________

Family Physician (if any): ____
(Name, Address and Phone no.)

___________________________________ Identification Mark: _____________________________

History:

		If yes, give details
Diabetes	Yes / No	
High Blood Pressure	Yes / No	
Heart disease	Yes / No	
Asthma / TB	Yes / No	
Refyactive error	Yes / No	
Any other illness	Yes / No	

Examination:

[A] GPE Pulse: B.P.:

Mental State: Height: cms

Pallor: Weight: cms

Lymph Nodes:

Skin:

Nails:

ENT:

Vision	With Spectacles	Without Spectacles
Left Eye		
Right Eye		

[B] Systemic Exam:

Resp. System:

CVS:

Abdomen:

Genitorinary:

CNS:

Investigations

1 - Hb%

2 - Urine ∠ routine / micro

3 - Any other:

Comments:

Certified medically fit/unfit:

Date of Examination

Signature with stamp

Name of the Doctor:
Qualifications:
Reg. No.: