



FORM/HR/009-2

## HUMAN RESOURCE

### MEDICAL REPORT FORM *(This must be filled by Doctor)*

REF .....

DATE: .....

NAME: ..... GENDER: ..... L.M.P: .....

ADDRESS: .....

HEIGHT: ..... WEIGHT: .....

CHRONIC ILLNESS: .....

PAST MEDICAL HISTORY: .....

#### PHYSICAL EXAMINATION:

PALLOUR: .....

JAUNDICE: .....

LYMPHNODES: .....

#### VACCINATIONS-KEPI:

B.C.G: .....

POLIO: .....

MEASLES: .....

HEPATITIS B: .....

OTHERS: .....

#### VITAL SIGNS

TEMP: .....

PULSE: .....

RESPIRATION RATE: .....

BLOOD PRESSURE: .....

#### SPECIAL ORGANS

HEARING: .....

NOSE: .....

THROAT: .....

VISUAL QUALITY RT%LT WITH GLASSES

#### SYSTEMATIC EXAMINATION

CARRDIOVASCULAR SYSTEM: .....

CENTRAL NEVOUS SYSTEM: .....

RESPIRATORY SYSTEM: .....

GASTRO INTESTINAL SYSTEM: .....

MUSCULO SKELETAL SYSTEM: .....

#### LAB TEST

HAEMOGLOBIN: .....

URINALYSIS: .....

STOOL FOR MICROSCOPY: .....

PREGNANCY: .....

BLOOD SUGAR: .....

OTHERS: .....

**RADIOLOGICAL SCREENING (Where indicated)**

Chest: .....

Others: .....

**COMMENTS**

.....  
.....  
.....

**MEDICAL OFFICER/REGISTERED CLINICAL OFFICER**

NAME: .....DESIGNATION: ..... SIGNATURE: .....

DATE: .....OFFICIAL STAMP: .....

