Health Evaluation Form

Date _____ Candidate's Signature _____

Name _____ Age _____ Sex _____

Mark of Identification _____

Family History : TB, Asthma, Eczema, Diabetes, Hypertension, Rheumatism and Cancer

_____

_____

Past History : Operation, Injury, Major illness and Allergy

_____

_____

Personal History : Diet : Veg./Non-Veg./Mixed. Blood Group : _____

Present medications taken : _____

Smoking _____ Alcohol _____ Tobacco _____

General Examination:

General appearance and build

Height _____ Cms. Weight _____ Kgs.

Eyes: Vision : Without Glasses Lt. _____ Rt. _____

With Glasses Lt. _____ Rt. _____

Colour Vision _____ Squint _____

Cornea _____ Conjunctiva _____

Pupils _____

Ears Hearing _____

Nose _____ Throat _____

Teeth & gums _____ Tonsils _____

Tongue _____ Skin _____

Varicose Veins _____

Systematic Examination

C.V.S. :

Heart Size _____ Heart Sounds _____

Murmurs _____

Pulse _____ /Min. B.P. _____ mm. of Hg.

R.S. :

Air entry _____

Breath Sounds _____

Adventitious Sounds _____

G.I. System :

Liver _____ Spleen _____

Lump _____ Tenderness _____

Hernia _____ Piles/Fissures _____

Genito-urinary System :

Hydrocoele _____ Varicocele _____

C.N.S. :

Muscle _____ Deep tendon reflexes _____

Muscle Power _____ Planter reflex _____

Sensations _____ Musculoskeletal System _____

E.C.G. : _____ X-RAY CHEST :

Remarks :