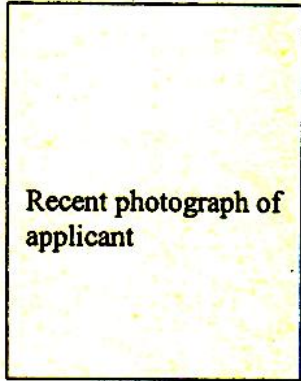


**KASTURBA COLLEGE OF NURSING
HABIBGANJ, BHEL, BHOPAL (M.P.) 462024**

MEDICAL EXAMINATION REPORT



To be completed by the applicant, who is responsible for answering each question accurately.*
Full Name and permanent address (please type or use block capitals)

Gender: Male/Female

Date of Birth _____

Do you have or had any of the following?

* If there are any terms on the attached list which are not understood, please consult your Doctor.

	No	Yes	Year		No	Yes	Year
Measles	---	---	---	Blood Vomiting or Blood in Stools	---	---	---
German Measles	---	---	---	Urinary Tract Infections	---	---	---
Chicken Pox	---	---	---	Blood in Urine	---	---	---
Whooping Cough	---	---	---	Urinary Tract Stones	---	---	---
Scarlet Fever	---	---	---	Renal Disease	---	---	---
Mumps	---	---	---	Difficulties in Passing Urine	---	---	---
Rheumatic Fever	---	---	---	Urinary Test Strictures	---	---	---
Congenital Anomalies	---	---	---	Goiter	---	---	---
Tuberculosis	---	---	---	Thyrotoxicosis	---	---	---
Pneumonia	---	---	---	Myxoedema	---	---	---
Pleurisy	---	---	---	Diabetes	---	---	---
Asthma	---	---	---	Other Endocrine Diseases	---	---	---
Chronic Bronchitis	---	---	---	Frequent Headaches	---	---	---
Recurrent Tonsillitis	---	---	---	Migraine	---	---	---
Recurrent Sinusitis	---	---	---	Poliomyelitis	---	---	---
Frequent Nose Bleeding	---	---	---	Epilepsy	---	---	---
Heart Valve Disease	---	---	---	Nervous Breakdown	---	---	---
Chest Pain	---	---	---	Psychiatric Disease	---	---	---
Irregular Heart Beats	---	---	---	Trachoma	---	---	---
High Blood Pressure	---	---	---	Cataract	---	---	---
Varicose Veins	---	---	---	Other Severe Eye Diseases	---	---	---
Inflammation in Veins	---	---	---	Skin Disease	---	---	---
Embolism or Thrombosis	---	---	---	Allergy	---	---	---
Intermittent Limping	---	---	---	Severe Anaemia	---	---	---
Gastric or Duodenal Ulcer	---	---	---	Pernicious Anaemia	---	---	---
Chronic Gastritis	---	---	---	Other Severe Blood Disorders	---	---	---
Recurrent Indigestion	---	---	---	Malaria	---	---	---
Gall Bladder Disease	---	---	---	Other Tropical Diseases	---	---	---
Jaundice	---	---	---	Any Malignant Diseases	---	---	---
Liver Disease	---	---	---				
Severe Intestinal Infections	---	---	---				
Haemorrhoids	---	---	---				

Any Surgical Operations?

Operation

Year

- (a) _____
- (b) _____
- (c) _____
- (d) _____

Serious Accidents

Injury

Year

- (a) _____
- (b) _____
- (c) _____
- (d) _____

Other Diseases:

- Are your menstrual periods regular?
- Do you have severe pain during your periods?
- Do you often have to stay at home during your periods?
- When was your last period?
- Do you take any medicines during your periods?

Which of the following vaccinations have you had? :

	Yes	No	Year
Smallpox
Tuberculosis
Whooping Cough
Tetanus
Diphtheria
Cholera
Yellow Fever
Measles
German Measles
Hepatitis
Others (specify)

Signature of the candidate..... Date:.....
(to be signed in the presence of examining Doctor)

Part 2 : MEDICAL EXAMINER'S REPORT

IMPORTANT : The Objective of the examination is to determine that the candidate is physically and mentally fit to undergo the Bsc Nursing Course at Kasturba College of Nursing Bhopal M.P.

Height:	cm.		Weight kg.	
Blood Pressure	Systolic	mmHg	Diastolic	mmHg
Pulse:	/min	Quality:	Regular?	Well filled?
Urine:	Spec. Gr.	Sugar :	Albumen:	Sediment:
Blood:	Hb:	Group		

General Appearance:

Consistent with stated age?

Cyanosis ?

Jaundice?

Pallor?

Other observations:

Eyes:	Vision:	R:	L:	Corrected:	R:	L:
	Pupils:					
	Eye movements:					
	Cataract:	R:	L:			
	Trachoma:	R:	L:			
	Fundus:	R:	L:			
	Other observations:					

Ears:	Hearing:	R:	L:
	Ear Drums:	R:	L:

Nose and Throat :

Mouth and Teeth :

Heart and Circulatory:

Heart Rate : /mins
 Heart Sounds
 Heart Rhythm:
 Palpable Arteriosclerosis:
 Varicose Veins:
 Odemas:

Chest :

Configuration:
 Movements:
 Respiratory Sounds:
 Respiration: /min

Abdomen:

Liver:

Spleen:

Palpable lumps:

Kidneys:

Hernias:

Reproductive Systems:(including breasts)

Psychiatric:

Mood:

Stability:

Sleep:

Neurological:

Paresis:

Reflexes:

Upper Limbs

Lower Limbs:

Skin:

Other Observations: HIV & HBSAg Test
(ATTACH THE MEDICAL REPORT)

Signature of the examining Doctor Date:.....

NOTE: THIS MEDICAL REPORT SHOULD BE STAMPED OR SEALED.

Name (Block letters please), Degree and Address.

