INSTITUTE OF ALLIED HEALTH JAMAICA

MEDICAL EXAMINATION FORM

PLEASE FILL IN ALL INFORMATION PRECISELY

CANDIDATE'S FULL NAME: ____

AGE:________________________________ **D.O.B.:**_____________________________

HEIGHT (FT. & ''):___________________ **WEIGHT:**___________________________

BLOOD PRESSURE:_________________ **PULSE:**____________________________

RESPIRATION:_____________________ **TEMPERATURE:**___________________

VISION: (A) WITH GLASSES____________ **(B) WITHOUT GLASSES:**___________

URINALYSIS: NOR. /ABN __________________

FULLY IMMUNIZED: _____________________

SECTION A

HAVE YOU EVER SUFFERED FROM OR RECEIVED TREATMENT FOR:

A. TUBERCULOSIS - (TB): ☐ YES ☐ NO

B. EPILEPSY - (FITS): ☐ YES ☐ NO

C. DIABETES - (SUGAR): ☐ YES ☐ NO

D. HYPERTENSION - (PRES): ☐ YES ☐ NO

E. SICKLE CELL DISEASE: ☐ YES ☐ NO

F. PEPTIC ULCER DISEASE: ☐ YES ☐ NO

G. MIGRAINE HEADACHES: ☐ YES ☐ NO

H. HEART DISEASE: ☐ YES ☐ NO

I. ARTHRITIS: ☐ YES ☐ NO

J. ASTHMA: ☐ YES ☐ NO

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K. ANY MENTAL OR MOOD DISORDER: ☐ **YES** ☐ **NO**

SECTION B

ON EXAMINATION, ANY ABNORMALITY OF THE FOLLOWING:

A. EYES, EARS, NOSE AND THROAT: ____

B. SKIN: ____

C. RESPIRATORY SYSTEM: ____

D. HEART: ____

E. ABDOMEN: ____

F. GENITOURINARY SYSTEM: ____

G. ENDOCRINE SYSTEM: ____

H. MUSCULOSKELETAL SYSTEM (SPINE, JOINTS)

ETC.:________________________________

I. ANY HEMORRHOIDS (PILE): ____

J. ANY OTHER ABNORMALITIES:

____

COMMENTS:____

DATE: ____

DOCTOR’S NAME: ____

DOCTOR’S CONTACT NUMBER: ______________________________________

DOCTOR’S SIGNATURE & STAMP: ___________________________________