



ALL INDIA INSTITUTE OF MEDICAL SCIENCES, BIBINAGAR,

Hyderabad Metropolitan Region, TELANGANA - 508126

अखिल भारतीय आयुर्विज्ञान संस्थान, बीबीनगर,

हैदराबाद मेट्रोपोलिटन क्षेत्र, तेलंगाना - 508126

MEDICAL EXAMINATION REPORT

CANDIDATE'S STATEMENT & DECLARATION

The Candidate must make the statement required below prior to his medical examination and must sign the Declaration appended thereto.

Photograph

1. State your name in full
(in Block Letters): _____
Father's Name : _____
2. State your age & Birth Place : _____
3. (a) Have you ever had small-pox intermittent or any other fever, enlargement or suppuration of glands spitting of blood, asthma, heart disease, fainting attacks, Rheumatism, Appendicitis ?

- (b) Any other disease or accident requiring confinement to bed and medical or surgical treatment? : _____
4. History of vaccination : _____
5. Have you or any of your near relations been afflicted with gout, asthma, fits, or insanity?

6. Have you suffered from a degree of deafness : _____
7. Have you suffered from any form of nervousness due to over work or any other cause :
8. Furnish the following particulars concerning your family (disease trend in family and premature death if any) : _____

Above statements are true and I have not suppressed any information.*

Candidate's Signature

Signed in my Presence Chairman of the Board

* Note : - The candidate will be held responsible for the accuracy of above statements.

* For female candidate – **Chest radiograph to be done only after gynecology clearance.**

Report of the Medical Board on

Name of the Candidate :-

1. i) Height (Without shoes) _____ cm, Weight _____ kg

Chest circumference : After full inspiration _____ cm full Expiration _____ cm

ii) Respiratory system _____

iii) Circulatory system

(a) Heart : Any organic lesions : _____

Rate Standing _____

ECG (pl attach) – date-

Please mention abnormality if any

(b) Blood pressure _____ pulse rate _____ spO2 _____ in room air

iv) Nervous system : _____

v) Loco Motor system : _____

vi) Skin: (any obvious disease)

Remarks

(Name & Signature Faculty of Medicine)

2. **Eyes** : (a) Any disease : Yes (mention)/No _____

(b) Defect in colour vision : Normal/Abnormal (mention)

(c) Field of vision : Normal/Abnormal (mention)

(d) Visual acuity : _____

	Acuity of vision	Without glass	With glass
Near Vision	Right Eye Left Eye		
Distant Vision	Right Eye Left Eye		

Remarks

(Name & Signature of Faculty Ophthalmology)

3. Ears Inspection _____ Hearing _____ Right Ear : _____

Left Ear: _____

Glands : _____ Thyroid _____

General condition of teeth and oral cavity _____

Remarks

(Signature of Faculty Otolaryngology)

4. Abdomen : Tenderness _____ Hernia _____

(a) Palpable : Liver _____ Spleen _____ Kidneys _____

Any others _____

Genito Urinary System : Hydrocele _____ Varicocele _____

(b) Haemorrhoids _____ Fistula _____ Varicose Vein _____

(c) Lymphadenopathy (Palpable) _____

Remarks

(Name & Signature of Faculty Surgery)

5. Gynaecologic history and examination (for female candidates) :

Status: Single/Married

Age at menarche: Yrs

History of Polycystic ovarian syndrome (PCOS): Yes/No

Last visit to gynaecologist and reason of visit: Yes/No

Last whole abdominal ultrasound done and indication Yes/No

Past history of Tuberculosis/intake of ATT: Yes/No

Past history of gynaecologic surgery/intake of chemotherapy: Yes/No

Menstrual cycle:

Length: Duration of flow: Regularity:

Associated dysmenorrhoea: Last menstrual period (LMP):

Examination: 1) lymphadenopathy/scars/other deformities:

2) Breasts and axilla for any evidence of Mass/abnormal discharge:

3) Abdomen examination

Remarks

(Name & Signature of Faculty, OBST & Gyn)

6. Haematology, Blood sugar, Urine analysis report (To be attached)

Blood group and RH factor-(if known)

Remarks (Please mention if any major abnormalities)

(Name & Signature of Faculty, Biochemistry)

7. Report of screening chest radiograph (no- date-

(Name & Signature of Faculty, Radio-diagnosis)

8. Psychiatry

- | | |
|--|--------|
| 1. Any emotional/adjustment issues in the past | Yes/No |
| 2. Any history of psychiatrist/mental health professional consultation in the past | Yes/No |
| 3. Any history self-harm in the past | Yes/No |
| 4. Any history of mental health problems in the family | Yes/No |
| 5. Any history of substance abuse | Yes/No |

Specify if yes.....

Mental state examination findings in brief

Remarks

(Name & Signature of Faculty, Psychiatry)

9. Mention if there is anything in the health of the candidate likely to render him/her unfit?

Note : Record their finding under one of the following categories and strike out others

- (i) Fit
- (ii) Unfit on the following reasons _____
- (iii) Temporarily unfit on account of

Chairman Medical Board

Seal/Name

Dated : _____

Special medical board opinion (if required)
