## Personal Information:

Student Name: .............................................................. Age: .......................... University ID: .....................................

## In Case of Emergency:

Name: .................................................... Contact Number: ............................. Relation: ..........................................

## Insurance (if present):

Name.................................................... Hospital: ..............................................

## Medical History:

| Symptoms | Yes | No | Symptoms | Yes | No |
|---|---|---|---|---|---|
| High Blood Pressure | | | Diabetes | | |
| Heart Disease | | | Epilepsy | | |
| Asthma | | | Anemia | | |
| Tuberculosis | | | Ear disease | | |
| Anxiety/Depression | | | Muscular disease | | |
| Visual Problem | | | Renal Problem | | |
| Menstrual Disorder | | | Recurrent Headache | | |
| Other: If yes, explain | | | | | |

## Investigation:

| Height: | |
|---|---|
| Weight | |
| Blood pressure | |
| Heart | |
| Abdomen | |
| Chest | |

## Allergies:

| Type | Yes | No |
|---|---|---|
| Food | | |
| Drug | | |
| Other: If yes, explain | | |

## Examination:

| Blood Sugar | |
|---|---|
| Urine analysis | |
| Chest X-Ray | |
| Blood Type | |

## History of vaccination: Taken ☐ Not Taken ☐

Comments: ..........................................................................................................................................

Hospital Stamp:

Physician's Signature: ................................................ Date: ..............................

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