INDIAN SCHOOL AL WADI AL KABIR
MEDICAL HISTORY

1. NAME: ……………………………………………………………………………….

2. AGE ………………….

3. Are you to the best of your knowledge and belief free from any illness or disability YES / NO

4. Have you ever suffered from:

	YES / NO	If yes, give details
Migraine/Severe Headache		
Epilepsy / Fits / Faints		
Eye disease		
Tuberculosis		
Asthma		
Joint Pains		
Nervous Breakdown		
Skin diseases		
Heart Disease / Chest Pain		
Gastric / Duodenal Ulcer		
Psychiatric Illness		
High Blood Pressure		
Allergic conditions		
Diabetes		
VDRL		
AIDS		
Any other injury / illness		

5. Have you had any surgical operations YES / NO
   If yes, give details ……………………………………………………………………………..
   ……………………………………………………………………………..
   ……………………………………………………………………………..

6. Are you presently taking any medicines or undergoing treatment of any kind: YES / NO

   If yes, give details …………………………………………………………………………….
   …………………………………………………………………………….
   …………………………………………………………………………….

Place:

Date : Signature: