TO BE FILLED IN BY CANDIDATE MEDICAL DETAILS

Permanent Address **Present Address**

_____ _____

_____ _____

_____ _____

_____ _____

Answer all Questions: Put (√) Mark in the Column "Yes" /"No."

Sr No.	Question	Yes	No.
1	Are you on any prolonged medication?		
	If Yes, Specify		
2	Are you allergic to any medicine?		
	If Yes, Specify:		
3	Do you suffer from any of the following		
	. High Blood Pressure		
	. Heart Disease		
	. Tuberculosis		
	. Stroke/Paralysis due to Hemorrhage in Brain		
	. Diabetes		
	. Mental illness		
	. Cancer		
	. Any other disease, Pl Specify		
4	Do you take alcoholic beverages / intoxicants?		
5	Do you smoke or take tobacco? If Yes, How much every day		
6.	Do you have fainting spells?		
7	Do you become unusually short of breath when you walk upon flight of stairs?		
8	Have you had a cough that started in the last 6 months & remained more than a month?		
9	Have you ever vomited or coughed out Blood?		
10	Do you have weakness of paralysis of either of your arms or legs?		
11	Do you ever feel depressed that if interferes with you jobs or with your doing house work?		
12	Do you feel that you need medical or psychiatric help because of nervousness?		
13	Have you ever been rejected in Pre-Employment Medical Examination. If yes, name of the company, where you got appointment:_____		

14	Do / Did any of your family member(s) suffer(ed) from any of the following.		
	. High Blood Pressure		
	. Heart Disease		
	. Tuberculosis		
	. Stroke/Paralysis due to Hemorrhage in Brain		
	. Diabetes		
	. Mental illness		
	. Cancer		
15	Do you have Hernia / Piles / Hydrocele		
16	Please specify significant information, if any not covered above:		

Marital History : Single / Married/ Widow/ Widower / Divorced

No. Of Children: Male_____ Female _____

F P History : Vasectomy / Tubectomy

Immunization: Tetanus toxoid : I II III Booster: I II
Hepatitis B : I II III

PAST EMPLOYMENT IF ANY:

	Name of the Company	No. of Years	Nature of Job	Any occupational health Ailment

DECLARATION BY CANDIDATE
I declare that the above information is true and correct to the best of my knowledge and belief

Date:_____

Place:_____ **Signature of Candidate**

FINGER PRINT OF THE LEFT HAND FINGERS

Little Finger	**Ring Finger**	**Middle Finger**	**Index Finger**	**Thumb**