



# Health Check - Medical History Form

We request you to take more time and fill up this form, Thank you.

0451 / HEALTH CHECK / 2009



HH No. :	Age :	Sex :
Name :		
(Last)	(First)	(Middle)

*Please tick the appropriate option*

## 1. Personal History

i	Do you smoke / chew tobacco / snuff?	Yes / No	_____ / day for _____ years
ii	Do you consume alcohol?	Yes / No	_____ / day for _____ years
iii	Is your urination normal?	Yes / No	
iv	Are your stools normal?	Yes / No	
v	Are you married?	Yes / No	_____ children
vi	Do you exercise regularly?	Yes / No	
vii	Diet?	Vegetarian / Mixed	

## 2. Past History

Duration

i	Allergy (Any particular drug)?	Yes / No	
ii	Diabetes?	Yes / No	
iii	High Blood Pressure?	Yes / No	
iv	Coronary Heart Disease?	Yes / No	
v	Tuberculosis (TB)?	Yes / No	
vi	Asthma?	Yes / No	
vii	Thyroid Problem?	Yes / No	

## 3. Family History \_\_\_\_\_

## 4. Have you undergone any operation / procedure before?

Please specify, if any \_\_\_\_\_

## 5. Current Treatment / Medications

Please specify, if any \_\_\_\_\_

## 6. Present Health complaints \_\_\_\_\_

Date : \_\_\_\_\_

Signature : \_\_\_\_\_