MEDICAL FORM

Surname:	Other names:	Date of Birth:	Gender:

TO BE FILLED OUT BY APPLICANT

	Have you/or do you suffer from any of the following:	Yes	No	If yes please specify
1	Hypertension			
2	Diabetes			
3	Epilepsy			
4	Mental disorder			
5	Tuberculosis			
6	Bronchial asthma			
7	Visual disorder			
8	Malaria			
9	Sexually transmitted diseases (including AIDS)			
10	Are you currently on any medication?			
11	Are you currently pregnant?			

TO BE FILLED OUT BY FAMILY PHYSICIAN /PRACTIONER

	Has the applicant suffered /suffering from the following:	Yes	No	If yes, please specify
1	Hypertension			
2	Diabetes			
3	Epilepsy			
4	Mental disorder			
5	Tuberculosis			
6	Bronchial asthma			
7	Visual disorder			
8	Malaria			
9	Heart (cardiovascular)			
10	Malignant disorder			
11	Sexually transmitted diseases (including AIDS)			
12	Gynecological disorders			
13	Currently on any medication?			
14	Currently pregnant?			

PHYSICAL EXAMINATION: PLEASE SPECIFY

1	Blood pressure						
2	Cardiac functions						
3	Liver						
4	Lymph nodes						
5	Respiratory						
6	Edema of legs						
7	Spleen						
8	Any other						
9	Lab tests	ESR	HB/HCT	WBC	HIV	URINE GLUCOSE	URINE PROTEIN
	Results						
10	Physician's conclusions /General remarks:						
	Physician's name:			Signature and stamp:		Date:	