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| **FORM/HR/009-2**  |



**HUMAN RESOURCE**

**MEDICAL REPORT FORM *(****This must be filled by Doctor)*

**REF ………………………….. DATE: …………………………..**

NAME: ………………………………… GENDER: …………….. L.M.P: ………………………………..

ADDRESS: ……………………………………………………………………………….....................................

HEIGHT: …………………………………… WEIGHT: …………………………………...................

CHRONIC ILLENESS: ……………………………………………………………………………......................

PAST MEDICAL HISTORY: …………………………………………………………………….......................

**PHYSICAL EXAMINATION:**  **VACCINATIONS-KEPI:**

PALLOUR: …………………………… B.C.G: ………………………………..

JAUNDICE: …………………………... POLIO: ……………………………....

LYMPHNODES: ……………………... MEASLES: …………………………..

 HEPATITIS B: ………………………

 OTHERS: ……………………………

**VITAL SIGNS** **SPECIAL ORGANS**

TEMP: ……………………………….. HEARING: …………………………..

PULSE: ……………………………… NOSE: ……………………..................

RESPIRATION RATE: …………….. THROAT: ……………………………

BLOOD PRESSURE: ………………. VISUAL QUALITY RT%LT WITH GLASSES SYSTEMATIC EXAMINATION

CARRDIOVASCULAR SYSTEM: ……………………………………………………………………………… CENTRAL NEVOUS SYSTEM: …………………………………………………………………………………

RESPIRATORY SYSTEM: ………………………………………………………………………………………

GASTRO INTESTINAL SYSTEM: ………………………………………………………………………………

MUSCULO SKELETAL SYSTEM: ………………………………………………………………………………

**LAB TEST**

HAEMOGLOBIN: …………………………………………………………………………………………………

URINALYSIS: ……………………………………………………………………………………………………

STOOL FOR MICROSCOPY: …………………………………………………………………………………… PREGNANCY: ……………………………………………………………………………………………………

BLOOD SUGAR: …………………………………………………………………………………………………

OTHERS: …………………………………………………………………………………………………………

**RADIOLOGICAL SCREENING** (Where indicated)

Chest: ………………………………………………………………………………………………………………

Others: ……………………………………………………………………………………………………………

**COMMENTS**

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**MEDICAL OFFICER/REGISTERED CLINICAL OFFICER**

NAME: ………………………………DESIGNATION: …………………. SIGNATURE: ……………

DATE: ……………………………….OFFICIAL STAMP: ……………………………. ……

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