

SARAWAK CHINESE ANNUAL CONFERENCE
THE METHODIST CHURCH IN MALAYSIA
18, ISLAND ROAD, 96000 SIBU,
SARAWAK
TEL: 084-332708
Medical Examination Form

Name : _____ Date of Birth : _____

Address : _____

1. Medical history of patient (serious, illnesses, infections, operations)

2. General Condition _____
3. Weight _____
4. Skin _____
5. Ears _____
6. Eyes _____
7. Breasts (female students) _____
8. Thyroid _____
9. Cardio-Vascular System
a. Heart _____
b. Blood pressure _____ c. Pulse _____
d. Veins _____ e. HB _____ %
10. Glands _____
11. Respiratory System
a. Nose _____
b. Lungs (Negative Chest Ray required)

c. X-Ray _____
12. Alimentary System
a. Mouth and Pharynx _____ b. Teeth _____
c. Abdomen _____ d. Stool _____
13. Urinary System _____
Urine Test _____
14. Nervous System _____
Headaches _____ Sleep _____
15. General Remarks _____
16. Vaccinations and Inoculations _____

Name of Examining Doctor: _____

Address of Examining Doctor: _____

Signature: _____ Date: _____