



BUGANDO UNIVERSITY COLLEGE OF HEALTH SCIENCES

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MEDICAL CERTIFICATE

SURNAME.....OTHER NAMES.....
AGE.....SEX.....
MARITAL STATUS.....CITIZENSHIP.....

PERSONAL HISTORY

Is the examinee suffering from any of the following? Indicate Yes or No.

- | | |
|---|---------------------------------|
| 1. Tuberculosis..... | 2. Pneumonia..... |
| 3. Pleurisy..... | 4. Asthenia..... |
| 5. Rheumatic Fever..... | 6. Allergy disorder..... |
| 7. Heart Disease..... | 8. Gastric or duodenal..... |
| 9. Recurrent indigestion..... | 10. Jaundice..... |
| 11. Dysentery..... | 12. Varicose Veins..... |
| 13. Kidney or urinary disease..... | 14. Diabetes..... |
| 15. Epilepsy..... | 16. Deformity..... |
| 17. Psychotic..... | 18. Eye disorder..... |
| 19. Ear , Nose or Throat disorder..... | 20. Skin disease..... |
| 21. Anemia..... | 22. Gynecological disorder..... |
| 23. Malaria other tropical disease..... | 24. Cholera..... |
| 25. Major or minor operations..... | 26. Serious accidents..... |
| 27. Any other serious disorder..... | |

PHYSICAL EXAMINATION

- | | |
|--|--|
| 1. Height..... | 2. Weight..... |
| 3. Skin disease..... | 4. Eye Conjunctivae
Pupils.....
Vision Right.....
Left..... |
| 5. Please state condition of Ears (if any discharge).....
Mouth and throat
Nose..... | |
| 6. Any Abnormality..... | |
| 7. Cardiovascular System.....
Blood Pressure: Systolic.....Diastolic.....
Heart: Any Murmur?.....
Arteries and Veins..... | |
| 8. Abdomen.....Hernia..... | |

