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HEALTH CHECK REPORT

NAME :

REG NO. :

AGE / SEX :

DATE :

DOB :

ADDRESS :

TEL :

FOR FEMALES ONLY :

MAIL :

PERIODS :

MARITAL STATUS :

LMP :

NO. OF CHILDREN :

PREGNANT :

CIGARETTES / TOBACCO / ALCOHOL :

IF PREGNANT NO X-RAYS PLEASE

REF BY :

HISTORY :

EXAMINATION :

HEIGHT : cms

LUNGS :

WEIGHT : kgs

HEART SOUNDS :

BP : mm Hg

LIVER :

PULSE : / min. Regular

SPLEEN

CONCLUSION AND REMARKS :

