Lokseva Pratishthan's

LOKSEVA COLLEGE OF PHARMACY

(Approved by AICTE, PCI,DTE, Govt. of Maharashtra & Affiliated to MSBTE)

S.No. 200/1B, Phulgaon, Taluka- Haveli, Dist.- Pune 412 216 Ph.: (02137) 320340

HEALTH RECORD FORM

Name: Mr. /Ms. /Mrs. ______________________________

Address: ______________________________

____

Contact No: ______________________

Date of Birth: / / **Age:** __________ (years) ________ (Months)

Blood Group: **Height**: __________ (cm)

Weight (Kg):

Identification Marks: 1)______________________________

2) ______________________________

Family Medical History: ______________________________

____

(TO BE FILLED BY THE FAMILY PHYSICIAN OR MEDICAL OFFICER ONLY)

Have you now or ever had any one or more of following?

	Yes	No		Yes	No
1. Heart Disease	☐	☐	13. Hernia	☐	☐
2. Rheumatic Fever	☐	☐	14. Poliomyelitis	☐	☐
3. Tuberculosis	☐	☐	15. Diptheria	☐	☐
4. Intestinal infection	☐	☐	16. Asthama	☐	☐
5. Epilepsy	☐	☐	17.Abnormal Bleeding	☐	☐
6. Psychiatric treatement	☐	☐	18. Hyperacidity	☐	☐
7. Vertigo	☐	☐	19. Typhoid	☐	☐
8. Fracture /Joint dislocation	☐	☐	20. Kidney Stone	☐	☐
9. Drug Interaction	☐	☐	21. Allergy	☐	☐
10. Appendicitis	☐	☐	22.Audio/Visual Defects	☐	☐
11. Anemia/Physical Weakness	☐	☐	23. Tonsillitis	☐	☐
12. Hepatitis	☐	☐	24. Any Other	☐	☐

Please explain in detail, if suffering from any Disease/ Disorder.

FINAL REMARK OF PHYSICIAN

1. He/ She is Physically Fit ☐ Unfit ☐ / Mentally Fit ☐ Unfit ☐
2. I recommend ☐ /not recommend ☐ him/her for admission

Name of Doctor & Reg. No.:

Designation:

Address:

Date:

Sign & Seal of Physician

I Mr. / Ms / Mrs. ____ hereby declare that, all the known facts regarding past and present medical record of my child have been brought to the notice of the medical officer. In case of any reoccurrence of disease / disorder /condition, Institute will not be responsible.

Name and Signature of Parent/ Guardian