panchvati

Medical information

Name

Age Sex Male Female

Are you suffering from

1. Heart problem
2. Diabetes
3. Blood pressure(high or low)
4. Any other chronic illness requiring prolonged treatment
5. Any communicable disease

6. Visual /hearing problem _____

_____

_____

7. History of past illnesses which required hospitalization/ surgery (pls give details of your age at that time)

_____

_____

_____

_____

8. Your own doctor

Name _____

Contact information _____

General Information

1. Any allergies_____

2. Addictions

- Smoking ☐ Yes ☐ No
- Alcohol ☐ Yes ☐ No
- Drugs ☐ Yes ☐ No

3. Any disability requiring assistance _____

4. Any diet restrictions _____

_____

_____

5. Anything else you want us to know about you_____

_____

_____

Signature of resident _____

Signature of registered medical practitioner _____

Place_____ date ___/___/_____