ALL INDIA INSTITUTE OF MEDICAL SCIENCES DEOGHAR
(स्वास्थ्य एवं परिवार कल्याण मंत्रालय , भारत सरकार के अधीन राष्ट्रीय महत्व का संस्थान)
(An Institution of National Importance under Ministry of Health & Family Welfare)
भारतसरकार/ Government of India

MEDICAL EXAMINATION REPORT

NAME: .....

POST SELECTED FOR: .....

DEPARTMENT: .....

ADDRESS :(PERMANENT) .....

.....

ADDRESS: (CORRESPONDENCE).....

.....

Email:

.....

MOBILE NO: .....

AADHAR NO. (OPTIONAL): .....

TWO IDENTIFICATION MARKS:

.....

.....

Candidate's Signature

STATEMENT AND DECLARATION

The candidate must make the statements required below prior to his Medical Examination and must sign the Declaration appended there to his attention is specially directed to the warning contained in the note below:

1. State your Name in Full (In Block Letter): .....

2. State your DOB and birth place .....

3. Are you? Single/ Married/Widow/Widower: .....

4. Name any major disease you have suffered from: .....

5. Are you being treated for any disease at present: .....

6. Have any of your near relations been afflicted with insanity, tuberculosis, diabetes mellitus, allergic disorders, gout, excessive bleeding: .....

.....

7. Are you allergic to any substance/ drug: .....?

8. Have you been immunized against the mentioned diseases (strike off whichever is not applicable)?

a) Hepatitis B: Yes/ No

b)Polio: Yes/ No

c) Diphtheria: Yes/ No

d) Tetanus: Yes/ No

e) Tuberculosis: Yes/ No

f) Any Other Vaccination: .....

All the above answers are to the best of my behalf, true and correct.

Candidate's Signature

Note: The candidate will be held responsible for the accuracy of the above statement. By wilfully suppressing any information it will incur the risk of losing admission.

14. Have you been immunized against the mentioned diseases (strike off whichever is not applicable)?

a) **History of Vaccination: _____**

b) **Hepatitis B: Yes/No**

c) **Polio: Yes/No**

d) **Diphtheria: Yes/ No**

e) **Tetanus: Yes/ No**

f) **Tuberculosis: Yes/ No**

g) **Any Other Vaccination: .....**

All the above answers are to the best of my belief, true and correct.

Candidate's Signature

Note: The candidate will be held responsible for the accuracy of the above statement. By willfully suppressing any information it will incur the risk of losing admission.

Signed in the presence of Chairman of the Board

Name of the Candidate: .....

DEPARTMENT OF GENERAL MEDICINE:

Physical Examination (Tick wherever appropriate)

General Appearance	Good		Fair		Poor	
Height (without shoes) (in cm)						
Weight (without shoes) (in kg)						
Pulse (rate/minute)						
Blood Pressure (mmHg) Systolic /Diastolic						
Oral Hygiene	Good		Fair		Poor	
Cyanosis	Present		Absent			
Pallor	Present		Absent			
Icterus	Present		Absent			
Pedal Edema	Present		Absent			
Clubbing	Present		Absent			

General Examination:

- **Chest circumference:**
  After full inspiration _____ cm Expiration _____ cm
- **Respiratory system_____**
- **Circulatory system _____**
- **Heart any organic lesions: _____**
- **ECG (Please attach) date with comment _____**
- **Please mention place ____**
- **Nervous system _____**
- **Loco Motor system (Any obvious abnormality): _____**
- **Skin (any obvious disease) _____**

Remarks (if any) _____

Signature, Name and Stamp of Faculty General Medicine

Name of the Candidate: .....

DEPARTMENT OF OPTHALMOLOGY

Vision	Distant vision		Near Vision		Color vision	
	Without glasses	With glasses	Without glasses	With glasses	Normal	Abnormal
Left Eye						
Right Eye						

(a) Any disease: Yes/No
(b) Detect in colour vision: Normal /Abnormal (mention)_____
(c) Field of vision: Normal) Abnormal (mention)_____
(d) Visual Acuity _____

Remarks (if any) _____

Signature, Name and Stamp of Faculty Ophthalmology

DEPARTMENT OF ENT

Ears Inspection _____

Hearing_____ Right Ear_____ Left Ear: _____

Glands: Thyroid _____

Remarks _____

Angle- Squint axis Hearing

	Normal	Abnormal
Left Ear		
Right Ear		

Remarks (if any) _____

Signature, Name and Stamp of Faculty ENT

Name of the Candidate: .....

DEPARTMENT OF GENERAL SURGERY

(a) Abdomen

- **Tenderness _____**
- **Hernia _____**
- **Palpable Liver _____**
- **Spleen _____**
- **Kidneys_____**

Any other_____

(b) Genito Urinary system

- **Hydrocele_____**
- **Varicocele _____**
- **Fistula**
- **Hemorrhoids_____**
- **Varicose vein _____**

(c) Lymphadenopathy (palpable)

Remarks _____

Signature, Name and Stamp of Faculty of General Surgery

Name of the Candidate: .....

DEPARTMENT OF OBSTRETRICS AND GYNAECOLOGY

Gynecology History and Examination (for Female candidates):

- **Status- Single/married/widow**
- **Age at menarche:**
- **LMP:**
- **History of Polycystic ovarian syndrome (PCOS): Yes/ No**
- **Last visit to gynecologist and reason of visit: Yes/ No**
- **Last whole abdominal ultrasound done and indication: Yes/ No**
- **Past history of tuberculosis intake of /ATT: Yes/ No**
- **Past history of gynecologic surgery / intake of chemotherapy: Yes/ No**
- **Any obvious gynecological abnormality Yes/ No**
- **Associated dysmenorrhea:**
- **Examination:**

(1) Lymphadenopathy/ Scars/ other deformities:

(2) Breasts and axilla for any evidence of Mass/abnormal discharge:

(3) Abdomen examination

Menstrual cycle:

Length: _____Duration of flow: _____ Regularity: _____

Signature, Name and Stamp of Faculty of Obstetrics and Gynecology

Name of the Candidate: .....

DEPARTMENT OF BIOCHEMISTRY/PATHOLOGY

Investigations (Attach All Reports)-

1. **Ref. No. for Blood sample:**
2. **Ref. No. for Urine sample:**

Hematology:

a) CBC:

b) LFT:

c) RFT:

d) Blood. Sugar:

e) Blood group and Rh factor:

Urine Examination:

Remarks (mention if any major abnormalities)

Signature, Name and Stamp of Faculty Biochemistry/Pathology

Chest X Ray findings

Reference no. & Date

Comment: .....

Name of the Candidate: .....

FINAL ASSESSMENT OF THE STANDING MEDICAL BOARD

(The Board should record their findings under one of the following three Categories)

1. **Fit: Fit/ Unfit**
2. **Unfit on the following reasons .....**

   .....
3. **Temporarily Unfit on account of.....**

   .....

   .....

Special medical board opinion (if required) _____

- **Member Secretary Standing Medical Board (Deputy Medical Supt.) _____**
- **Chairman Standing Medical Board (Medical Superintendent) _____**