MEDICAL CERTIFICATE

General

1. Name _____
2. Age _____yrs
3. Sex _____ (M/F) 4. Height _____cms 5. Weight _____kg
6. Blood group _____
7. Identification Mark: a) _____
   b) _____
8. Family History L Any Family H/O. (a) Hypertension _____(Y/N)
   (b) Heart Disease _____(Y/N)
   (c) Bleeding Disorder _____(Y/N)
   (d) Mental Disease _____(Y/N)
9. Personal History:-

Have you suffered from any of the following diseases? (Answer in Y/N in bracket)

a)	Chronic Bronchitis/Asthma	( )	b)	Pleurisy /TB	( )
C)	Rheumatism/frequent throat	( )	d)	Kidney/Bladder Trouble	( )
e)	STD	( )	f)	Jaundice	( )
g)	Mountain Disease	( )	h)	Any Eye Disease	( )
i)	Surgery	( )	j)	Any Ear Disease	( )
k)	Freq. Cough/Cold/Sinusitis	( )	l)	Fits/Faint Attack	( )
m)	Sever Heart Injury	( )	n)	Breast Disease	( )
0)	Amenorrhea	( )	p)	Pregnancy	( )
q)	Menorrhagia	( )	r)	Abortion	( )

10. Have you ever admitted in hospital for any illness, operation or injury ? If so, state the nature of the disease and duration of stay in hospital.

_____

_____

11. Any additional significant information about the health states.

_____

12. Have you ever been to a mountain before If yes specify the height and any problem found.

_____

Declaration :

I hereby declare that I have answered, fully as possible all the questions about my family and personal health and that the information given is true to the best of my knowledge.

Sign of MO _____
Date : _____

_____
Signature of the Candidate
NAME : _____
Date : _____

TO BE FILLED BY A REGISTERED DOCTOR

MEDICINE :

1. Urine Examination _____
2. Blood Examination: Hb ___ TLC ___ Neut ____ Lym ___ Mono ____ Eos ____
3. Physique and Skin _____ RBS _____ BT _____ CT _____.
4. CVS (a) Heart ____ b) Heart Sound ____ (c) PR ____/min (d) BP ____Min/Hp.
5. RS – (a) Chest Measurement: (b) full expiration _____cm (c) Range of expansion ____cm.
6. CNS – _____.
7. Speech, mental capacity and emotional stability: _____
8. Any other abnormality or condition affecting physical ability _____

Surgery

1 Upper limb : _____
2. Lower Limb : _____
3. Lumbar and sacral vt, Coccyx, Variase Vein
4. Gut and perineum (Hydrocoele, Varicocole, undescended testis, haemoroids)
5. Hernia and muscle : _____
6. Breast: _____
7 Any other abnormality or condition affecting physical ability _____

Eye:

1 Distant vision :

	W/o Glasses	Right	Left	near Vision	Right	Left
		_____	_____		_____	_____
	To Glasses	_____	_____		_____	_____

2. H/O any night blindness _____.

ENT:

1. Ear :-

	Right	Left
Hearing	_____	_____
Ext Ear	_____	_____
Middle Ear	_____	_____
Inner Ear	_____	_____

2. Nose: Any H/O DNS or Epistaxis _____.
   Anything significant _____.
3. Throat _____.

Dental: _____

Gynae: Menstrual history _____ LMP _____

No of Pregnancy _____ No of Abort _____

No of Children _____

Certified that I, on this date _____ examined _____ and found him medically fit o undergo _____ Mountaineering Courses.

Date _____ Signature _____

To be filled by Medical Officer