(Attachment 3)

Medical Checkup Sheet

Name _____

Date of Birth _____ / _____ / _____
Year Month Date

Sex Male Female (Please circle one)

Current Address _____

1. Weight _____
2. Height _____
3. Abdominal Palpation/ Stethoscope Test _____
4. X-Ray _____
5. Chest Problems _____
6. Eyesight
   With glasses
   Left_____ Right_____
   Without glasses
   Left_____ Right_____
7. Color Blindness _____
8. Blood Pressure _____
9. Urine Test _____
10. Hearing _____
11. Blood Sedimentation _____
12. Tuberculin Reaction
    Positive Negative
13. Past Illnesses _____
14. Chronic Illnesses _____
15. Allergies _____
16. Dietary restrictions _____
17. Blood type _____
18. Other _____

19. Alcohol ☐ Yes ☐ No (Amount:_____ per day/week/month)

20. Cigarette ☐ Yes ☐ No (Amount:_____ per day/week/month)

I hereby certify that the above details are correct.

Hospital _____

Address _____

Date _____ / _____ / _____
Year Month Date

Certified by _____

Signature _____