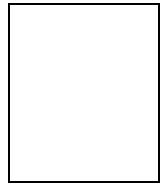


Student Health Performa



Arid No. _____

CNIC No. _____

Name: _____

Date of Birth: _____

Fathers Name: _____

Contact No. _____

Address: _____

Program Enrolled: _____ Semester : _____

History:

	Yes	No		Yes	No		Yes	No
HTN	<input type="checkbox"/>	<input type="checkbox"/>	DM	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>

Any surgery in past: _____

Blood group: _____

Vaccination for Hepatitis B

Examination:

BP: _____ mmHg Pulse: _____ /min Weight: _____ Kg Height: _____ cm

CVS: _____ Respiratory System: _____

Abdomen: _____ CNS: _____

General: _____

Signature of Examiner

Date of Examination

Official Stamp

PMDC No.