

Medical Data Form– Adult/Adolescent

Household ID: Member #:

Section A: Vital Info

1. Blood Group	4. Weight (kg)	7. Temperature (°C)	Remarks
2. RH Typing	5. Pulse Oxygen (%)	8. (a) Blood Pressure (Systolic)	
3. Height (cm)	6. Pulse Rate	8. (b) Blood Pressure (Diastolic)	

Section B: Medical History

Serial #	9. Ailment/Disease	10. From (Month/Year)	11. To (Month/Year)/Current
1			
2			
3			
4			
5			

Serial #	9. Ailment/Disease	10. From (Month/Year)	11. To (Month/Year)/Current
6			
7			
8			
9			
10			

Section C: Infectious Diseases

Serial #	12. Infection	13. Description
1		
2		

Serial #	12. Infection	13. Description
3		
4		

Section D: Allergies (if available: Drug/Food/Environment/Other)

14. Date (Month/Year)	15. Allergy Type	16. Description	17. Reaction	18. Treatment

Section E: Family History

Relation	19. Alive(Y)	20. Age (Years)	21. Afflictions
Father			
Mother			
Grand Father			
Grand Mother			

Relation	19. Alive(Y)	20. Age (Years)	21. Afflictions
Sibling 1			
Sibling 2			
Sibling 3			
Sibling 4			

Section F: ²²Dental Check (Recent Date): _____ & ²³Vision Check (Recent Date): _____

24. Complaint	25. From M/Y	26. To M/Y or Current
1		
2		
3		
4		

Vision	27. SPH	28. CYL	29. AXIS	30. PRISM
Distance – Right Eye				
Distance – Left Eye				
Near – Right Eye				
Near – Left Eye				

Section G: Life Style

DIET	31. From M/Y	32. To M/Y or Current
Salt Usage	35. High – Normal - Low	
Non-Veg. Consumption	36. High – Normal - Low	
Veg. Consumption	37. High – Normal - Low	
Sugar Consumption	38. High – Normal - Low	
Fruits	39. High – Normal - Low	
EXERTION LEVEL		
At Work	40. High – Normal - Low	
From Exercise	41. High – Normal - Low	

SLEEP PROBLEMS	33. From M/Y	34. To M/Y or Current
Snoring		
Daytime Drowsiness		
Interrupted Sleeping		
HEALTH HABITS		
Alcohol	42. Drinks per Week	
Tobacco	43. Packs per Day	
Caffeine	44. Cups per Day	
Drugs/Needles	45. Times per Week	

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Section H: Symptoms (ROS)

46. General
47. Cardiovascular
48. Respiratory
49. Eyes, ENT & Neck
50. Skin

51. Neurological
52. Gastroenterology
53. Women's Health (if female)
54. Other

Section I: Immunization & Vaccination

55. Primary Vaccination (Y/N)	56. Date (M/Y)
57. BCG Vaccination (Y/N)	
58. Polio Vaccination (Y/N)	
59. Flu Vaccination (Y/N)	

60. Anti-Tetanus (Y/N)	58. Date (M/Y)
61. Anti-Cholera (Y/N)	
62. Other 1(Y/N)	
63. Other 2 (Y/N)	

Section K: Surgeries & Hospitalization

64. Problem	65. Month/Year	66. Surgery (Y/N)	67. Hospitalized (Y/N)	68. Notes

Section L: Medications

69. Supplement (Y/N)	70. Medicine	71. Health Problem	72. Dosage	73. Dosage Type	74. Frequency	75. (M/Y) Start Date	76. (M/Y) End Date/Current	77. Physician

Section M: Maternal History (if Female and Age > 12 Years)

78. Age at Pregnancy	79. Delivered	80. Living	78. Age at Pregnancy	79. Delivered	80. Living	78. Age at Pregnancy	79. Delivered	80. Living	78. Age at Pregnancy	79. Delivered	80. Living

Section N: Problems of Adolescence (if Age > 12 and < 18 Years)

81. Puberty (Early/Late/Normal)
82. Obesity
83. Stature (Body Proportions)
84. Behavioural (Y/N – if yes describe)

85. Drug/Substance Abuse
86. Sex Related
87. Other (Male)
88. Other (Female)