

MEDICAL INTERROGATORY FORM FOR ENTRY INTO KSKCCS

Roll No _____

Name of Candidate: _____ S/O: _____

Complete Address : _____

_____ Contact No _____ Blood Group _____

Date of Birth: _____ Age: _____ Time of Medical Years: _____ Month: _____ Days: _____

DOES YOUR SON HAVE ANY HISTORY OF:-

NAME OF DISEASE	Yes/ No	NAME OF DISEASE	Yes/ No
Psychiatric Illness		Skin Disease	
Loss of sleep / frequent nightmares		Drug reactions / Allergies	
Walking in sleep / bedwetting upto 10 Yrs		Asthma or Hay Fever	
Frequent headache		Hypertension	
Fits or convulsions		Vertigo	
Sun stroke or Heat stroke		Rheumatism, Rheumatic fever	
Head injury with unconsciousness		Joint pains and swelling	
Bleeding from rectum		Diabetes Mellitus	
Gas or Pain after meals		Earache or Discharge from Ear	
Kidney stones		Frequent common colds	
Eye/Vision problems		Obstruction of nose	
Colour or Night Blindness		Jaundice (Yellow eyes)	
Sea, car or Travel sickness		Operations	
Any Congenital Disorder		Broken bones & dislocation of Joints	

Note: Please ensure that your ears are free of wax. You may consult your local doctor and get your ears examined and cleaned.

Family History

Have father, mother, brother or sisters of the applicant suffered from any of the following:-

Tuberculosis (TB) Yes / No Diabetes Mellitus Yes / No Fits Yes /No

Mental Disorders Yes / No Heart Disease Yes / No Hypertension Yes / No

Hepatitis Yes / No Asthma Yes / No

Declaration by the Parent / Guardian of the Candidate:-

I do hereby declare that the information stated above is complete and correct to the best of my knowledge, and that I have not withheld any relevant information. I am fully aware that by willfully suppressing any information, my son / ward incurs the risk of not being accepted for entry into KSKCCS or may be terminated from College if the information is found to be incorrect after his selection.

Date : _____

Signature of Parent / Guardian: _____

COUNTERSIGNED BY

Date: _____

Medical Officer DHQ Hospital _____