Darushifa
Elderly Care

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MEDICAL REPORT FORM

Private and Confidential
This form needs to be completed by a medical practitioner

Full Name	
Id No	
Address	
Sex	

Previous Medical History (please tick off relevant item's and give years of occurrence)

(a) Alimentary System

Peptic Ulcer ..... Chronic dyspepsia .....

Colitis ..... Appendicitis .....

Cholecystitis ..... Other .....

(b) Cardio Vascular System

Coronary Thrombosis ..... Hypertension .....

Congestive Failure ..... Rheumatic Fever .....

Anaemia ..... Peripheral vascular disease .....

Varicose Veins ..... Other .....

(c) Respiratory System

Bronchitis ..... Pneumonia .....

Asthma ..... Pneumoconiosis .....

Tuberculosis ..... Sinusitis .....

Emphysema ..... Other .....

(d) Genito- Urinary System

Nephritis …….. Renal- Calculus ……

Cystitis …….. Prostatism …….

Stricture …….. Cervicitis …….

Prolapse of Uterus &Vaginal Wall ……

Salpingitis …… Benign Tumors ……

Incontinency …….. Urine Analysis …….

Other ……..

(e) Nervous System

Cerebro-vasular accidents ……

Paralysis agitans …….. Epilepsy ……

Fainting Episodes …… Pheripheral neuritis ……

Other ……

(f) Metabolic

Weight …….. Obesity ……..

Diabetes …… Thyroid Disorders ……..

Vitamin Deficiency ……..

(g) Muscular Skeletal System

Previous Injuries …….. Osteoarthritis ……..

Rheumatoid Arthritis …… Osteitis ……..

Deformity due to any cause ……..

Wasting or weakness …… Other ……

(h) Skin

Dermatitis …… Eczema ……

Tumours …… Other ……

(i) Cancer of any parts of the body ……..

(j) Family History of Cancer ……

(k) Benign Tumors of any part of the body ……

(l) Allergies ……..

(m) Sight

Glaucoma …….. Cataract ……..

Vision: Corrected …….. Uncorrected ……..

Spectacles ……

(n) Hearing

Otitis Media …….. Osteosclerosis ……..

Hearing Aid ……

Surgical

List Operations

……

……

……

List any significant accidents, giving cause, nature of injury and residual effects

……

……

……

Mental Condition

List any previous psychotic episodes with dates if possible

……

……

Describe present mental condition

……

……

Describe intake of any tobacco or alcohol

……

Medication that you are currently on and dosage

……

……

……

Patient's Blood Pressure ……

Patient's Sugar ……

Patient's Cholesterol ……

Any General Comments

……

……

……

Name of Practitioner	
Date	
Address	
Contact Number	
Practice Number	

Medical Practitioners stamp (if available)

I confirm that I have examined this patient

……

Signature