**HEALTH REPORT**

|  |  |
| --- | --- |
| Surname: | First name: |
| Date of birth: | Male Female |
| Marital Status: | Blood Group: |
| Blood Pressure: |  |
| Height: cm | Weight: kg. |

**MEDICAL HISTORY**

Any Physical Disability (please specify):

Mental health problem (please specify):

Infectious condition (please specify):

Asthma: Diabetes: Epilepsy:

Any allergies (please specify):

**USE AND FREQUENCY OF:**

Tobacco:

Alcohol:

Recreational drugs:

**ANY OTHER RELEVANT MEDICAL CONDITIONS:**

Other comments:

Medication:

Date of examinations:

Medical Doctor`s signature: