CONFIDENTIAL

FIJI NURSING COUNCIL
MEDICAL EXAMINATION REPORT

A. PERSONAL INFORMATION (to be completed by candidate)

Name (as in Birth Certificate):

Surname: _____ Other Names: _____

DOB: ___ /____/ ____ Age: _____ yrs Gender: _____ Marital Status: _____

Father's Name: _____ Ethnicity: _____

Address: _____

B. MEDICAL HISTORY (to be completed by the Medical Officer/NP from answers given by the candidate)

(i) Have you suffered or suffering from:-

1.	Allergy *(if yes, details please)* _____	YES/NO	9.	Insanity, mental instability _____	YES/NO
2.	Asthma _____	YES/NO	10.	Kidney Disease _____	YES/NO
3.	Chest Complaint *(if yes, details please)* _____	YES/NO	11.	Leprosy _____	YES/NO
4.	Diabetes _____	YES/NO	12.	Malaria _____	YES/NO
5.	Discharge from ear or deafness _____	YES/NO	13.	Rheumatic Fever _____	YES/NO
6.	Epilepsy or fits _____	YES/NO	14.	Sexually Transmitted Infections ___	YES/NO
7.	Heart Disease _____	YES/NO	15.	Tuberculosis _____	YES/NO
8.	Hypertension _____	YES/NO	16.	Any other serious or chronic _____ disease: *(if yes, details please)*	YES/NO

Further details: _____

(ii) Any serious accident, personal injury, or surgical operation in the past? YES/NO *(if yes, details please)*

_____

(iii) Present general state of your health : _____

(iv) Menarche: _____ LNMP: _____

C. FAMILY HEALTH STATUS (Particulars regarding candidate's parents)

	IF LIVING		IF DECEASED	
	AGE	STATE OF HEALTH	AGE	CAUSE OF DEATH
FATHER				
MOTHER				

I hereby declare that I have carefully considered the statements made above, that to the best of my belief, they are complete and correct and that I have not withheld any relevant information or made any misleading statement and I give my full consent to the examining or assessing medical officer to communicate with any physician who has attended to me.

Signature of Client: _____ Witness: _____
(Examining Officer)

Date: _____

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MEDICAL REPORT

Weight:	Height:	BMI:	Blood Glucose:
Eyes	VAR: 6/		VAL: 6/
E.N.T.			
Chest x-ray			
Blood	Hb (G%)		Blood Pressure:
Heart	Breast Examination:		
Lungs	Pap-smear		
Abdomen			
C.N.S.			
G.U.S.			
L.N.M.P.			
Stool			
Urine	Albumen:	Sugar:	Deposit:

The Medical Officer/Nurse Practitioner should, in addition to any observations he may wish to add, make special reference to the condition of the candidate's eyesight and hearing in this space.

In my opinion this candidate is mentally and physically *FIT/NOT FIT to *undergo nurse training/employment

_____

(Name of *health/educational Institution)

Signature of Medical Officer/Nurse Practitioner: _____

Date: _____

Name in Full: _____

Name & Address of Hospital / H/C / Clinic: _____

Rubber Stamp

*** Delete where inapplicable**