Prin. L.N.Welingkar Institute of Management Development And Research, Mumbai-400019

Master of Management Studies

Medical History form

(A) To be filled by the Candidate

Photo

Full Name: ____

Surname First name Middle name

Gender: Male / Female Blood Group: ________________________

Course of Study: MMS - ____________________ Campus : _________________________

Tel No __________________ (Home) __________________ (Mobile)

Local guardian: ______________________Relationship: __________________________

Local guardian's Contact: __________________ (Home) __________________ (Mobile)

Family Physician Name and contact No:____

______________ (Home) ____________ (Mobile)

1. Do you wear glasses / contact lens? □ No □ Yes
2. Do you wear any dental appliance (bridge, crown, plate) □ No □ Yes

____

3. History of smoking □ No □ Yes #of cigarettes per day/week______ Since how long ________
4. History of alcohol □ No □ Yes How much ________ Since how long ________
5. Are you currently under medical treatment for any physical condition? □ No □ Yes
6. Are you currently under treatment or have been treated in the last five years by a psychiatrist, clinical psychologist, or other mental health professional? □ No □ Yes

If "Yes"to Question no 5 and / or 6, please provide details (diagnosis, treatment, date and duration, etc)

____

The information provided here will be strictly confidential and is to be used should any untoward incident occur.

7. Are you currently taking ANY MEDICATION on a daily basis? □ No □ Yes

If, YES, please list the medication and the conditions you are taking it for:

Medication	Condition

S.No	Condition	□ No	□ Yes	Comment (medications if any)
1	During or after exercise have you ever – - passed out - felt dizzy or lightheaded - had chest pain - had shortness of breath			

I understand that I am responsible for my own physical and mental health, and for informing staff of any need for treatment.

I hereby affirm that all information supplied is complete and accurate to the best of my knowledge.

I hereby grant permission to WeSchool to make necessary referrals; to release medical information necessary for appropriate care and treatment, and to authorize hospitalization when recommended in the event of illness or accident.

Parents, guardians, or local guardian will be promptly notified in the event of serious illness or accident, except when delay by such communication would endanger life. I understand that WeSchool cannot be held responsible for any medical incident occurring during my student days & for any financial obligations thereof.

Name of the student :___ ________________ ___________ Date _____________________

Signature of student : ___ ________________ _____________

Contact No: ____

Name of parent or guardian: ____________________ _____ Date _____________________

Signature of parent or guardian: : ___ ________________ _____________

Contact No:____

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(B) To be Filled by the Physician

1. **History of Allergy: Please tick and explain the reaction**

None	Medication	Food	Environmental

2. Personal Medical History/Disorder/Problem – Please tick with brief comment where applicable

S.No	Condition	□ No	□ Yes	Comment (medications if any)
1	H/o any medical illness lasting for more than six months			
2	H/o any medical illness requiring overnight hospitalization			
3	H/o previous surgery			
4	H/o diabetes			
5	H/o High or Low BP			
6	H/o Jaundice			
7	H/o Kidney disease			
8	H/o Thyroid			
9	H/o Asthma			
10	H/o Convulsions (fits) / Seizures requiring medical supervision			
11	H/o Ear Nose Throat problems			
12	H/o Tuberculosis			
13	H/o Skin Rash / Eczema / Dermatitis / other Skin Disease / Allergy?			
14	H/O COVID 19			
15	Both the doses of Vaccination taken?			

Name & Signature of Certifying doctor: ____

Doctor's Contact details: ______________ (Home) ____________ (Mobile)

Doctor Seal & Medical Council Registration Number

Place: ______________________ Date: ______________________

The information provided here will be strictly confidential and is to be used should any untoward incident occur.