



CAMEROON BAPTIST THEOLOGICAL SEMINARY

PO Box 44, Ndu
Northwest Region, Republic of Cameroon

PHYSICAL EXAMINATION REPORT (Valid only from CBC Health Board Facility)

NAME as it appears on National Identity Card: _____

Date of Examination: ____/____/____ Date of birth, if known, or approximate age: _____

Number of children: ____ Parents still living? Mother: ____ Father: ____

How many living brothers do you have (one father, one mother): ____ sisters: ____

How many brothers and sisters have died (one father, one mother): _____

HEALTH HISTORY: Have you had any of the following diseases in the past 5 years? If yes, give dates & frequency:

Boils: _____	Hernia: _____
Catarrh & Cough: _____	Kidney /Bladder Infection: _____
Diabetes: _____	Malaria Fever: _____
Dysentery: _____	Pneumonia: _____
Diarrhea: _____	Rheumatism: _____
Ear Trouble: _____	Stomach Ulcers: _____
Epilepsy: _____	Tuberculosis: _____
Eye Trouble: _____	Venereal Disease: _____
Filaria: _____	Worms: _____

FOR WOMEN ONLY:

Menstrual Cycle Regular: ____ Irregular: ____ Problems: _____

Deliveries (Give details of any problems): _____

HAS ANY MEMBER OF YOUR FAMILY EVER HAD:

Cancer ____ Epilepsy ____ Heart Trouble ____ Leprosy ____

Mental Trouble ____ Stomach Ulcers ____ Tuberculosis ____

HAVE YOU BEEN an in-patient in a hospital at any time during the past five years? ____

If yes, give the reason: _____

List any known allergies: _____

List any medications being taken at present: _____

PHYSICAL EXAMINATION: Height: _____ cm Weight: _____ kg

Condition of the following: Blood Pressure: _____ Eyes: _____ Ears: _____ Nose: _____

Throat: _____ Heart _____ (Pulse rate) Lungs: _____ Diaphragm/Stomach: _____ Liver: _____

Hernia: _____ Extremities: _____ Spine: _____

GENERAL PHYSICAL CONDITION: _____

LAB EXAMINATION: White Blood Count: _____ Hemoglobin: _____

Urinalysis: Sp Gr: _____ Albumin: _____ Sugar: _____ Micros: _____

Stool: _____ VD: _____ VDRL: _____ Code #: _____

IMMUNIZATIONS: Tetanus Immunization is required: _____

Record of other immunizations: _____

DOCTOR'S RECOMMENDATION: I recommend that before entering the course this individual have treatment for: _____

I believe the individual is CAPABLE / INCAPABLE (cross out one) of taking part in all school activities without danger to himself or to others. (Please elaborate here if you wish to make any modification of the above statement): _____

Doctor's Signature and Seal: _____