IN LIEU OF AFMSF-2 (Ver 2002)

MEDICAL EXAMINATION REPORT ON ENTRY

MEDICAL EXAMINATION HELD AT MH _____ ON.....

1. NAME IN FULL..... 2. ROLL NO...../GK

3. MARRIED/SINGLE SINGLE 4. DATE OF BIRTH.....

5. FOR ADMISSION TO SAINIK SCHOOL GHORAKHAL 6. RANK CADET/SSGK

7. INDENTIFICATION MARK 8. PERMANENT ADDRESS

1. _____ _____ 2. _____ _____	Affix Photo of Candidate

.....
.....
.....
.....
.....

PERSONAL STATEMENTS

9. FAMILY HISTORY

NAME	RELATION	If Alive		If Dead	
		Age (Years)	Health	Cause of Death	Year of Death
	Father				
	Mother				
	Brother/Sister				
	Brother/Sister				
	Brother/Sister				
	Brother/Sister				
	Brother/Sister				

Any Family History of	Hypertension	Heart Disease	Diabetes	Bleeding Disorders	Mental Disease	Night Blindness

Roll No. .....
Name .....

10. PERSONAL HISTORY

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING?

Illness	(Yes/No)	Illness	(Yes/No)
Chronic Bronchitis / Asthma		Discharge from ears	
Pleurisy / Tuberculosis		Any other Ear Disease	
Rheumatism/Frequent Store Throats		Frequent Cough & Cold/Sinusitis	
Chronic Indigestion		Nervous Breakdown/Mental illness	
Kidney /Bladder trouble		Fits/Fainting Attacks	
STD		Severe Head Injury	
Jaundice		(For Female Candidates Only)	
Air, Sea, Car, Train sickness		Breast Disease/Discharge	
Trachoma		Amenorrhoca/Dysmenorrhoca	
Night Blindness		Menorrhagia	
Laser treatment/Surgery for Eye		Preganancy	
Any other Eye disease		Abortion	

(a) Have you ever been rejected as medically unfit for any branch of the Armed Forces?.....
NOT APPLICABLE

(b) Have you ever been discharged as medically unfit from any branch of the Armed
NOT APPLICABLE

(c) Have you ever been admitted for any illness, operation or injury? If so state the nature of disease and duration of stay in hospital.....
.....

(d) Any other information which you can give about your health.....
.....

I hereby declare that I have answered as fully as possible all the questions about my family and personal health and that the information given is true to the best of my knowledge.

Cert - ni blindness
Corrective eye Surgen

Signature of MO.....
(At MH)

Signature of Candidate.....

Date.....

Date.....

CONFIDENTIAL

Roll No. .....

Name .....

EXAMINATION

MEDICINE

11 (a) Height without shoes cms		(b) Weight (actual) Kg (acceptable) Kg		(c) Leg Length *(for Pilots only)* cms	
(d) Urine Examination	Appearance	Albumin	Sugar	Sp. Gravity	
(e) Blood Examiatnion (i) Hb gm% (ii)Any other inv carried out					
(f) Physique					
(g) Skin					
(h) Abdomen (Liver & Spleen)					
(i) Cardio Vascular System (Heart Size, Sounds, Rhythm, Arterial Walls, Pulse Rate and BP)					
(j) Respiratory System (including X-ray examination when applicable)				Chest measurements Full expiration cms Range of expansion cms	
(k) Central Nervous System				Self Balancing R L	
(l) Strech, Mental capacity & Emotional stability					
(m) Endocrine conditions					
(n) Any other abnormalities or conditions affecting physical capacity not already noted					
Remarks					

Date

Signature of Medical Specialaist

SURGERY

12 (a) Upper Limbs (Fingers, hand, wrists, elbows, shoulder, girdles, cervical and dorsal vertebrae
(b) Lower Limbs (Hallux valgus rigidus, flat feet, joints, pelvis) & Gait.
(c) Lumbar and sacral vertebrae, coccyx and varicose veins
(d) Genito-urinary and perincum (Hydrocele, Varicocele, undescended testes and haemorrhoids)
(e) Hernia & Muscle
(f) Breast
Remarks

Date

Signature of Surgical Specialaist

CONFIDENTIAL

Roll No. .....
Name .....

EYE

13 (a) Distant Vision	R	L	(b) Near Vision	R	L	(c) CP
Without Glasses			Without Glasses			
With Glasses			With Glasses			

(c) Any evidence of Trachoma/its complication or any other disease.

(d) Binocular Vision & Grade

SPECIAL EXAMINATION WHEN APPLICABLE

Manifest Hypermetropia, Myopia R & L	Cover Test
Diaphragm Test (PD M ddox Wing Test)	Fundi & Media
Fields	Night Visual Capacity
Convergence { C cms / SC cms	Accommodation { R / L

Remarks

Date

Signature of Medical Specialaist

EAR NOSE & THORAT

14 (a) Ear

(i) Hearing	R	L	Both
FW	cms	cms	cms
CV			cms

	R	L
(Ii) External Ear (V/ax)		
(Iii) Middle Ear (Tympanic Membrane & Eustachian Tube)		
(Iv) Inner Ear (Cochlea & Vestibular Apparatus)		

(v) Audiometry Record (special exam when applicable)

(b) Nose

(c) Throat

Remarks

Date

Signature of ENT Specialaist

CONFIDENTIAL

Roll No.	.....
Name	.....

DENTAL

15	(a)	Total No. of Teeth	Missing / Unsaveable Teeth	
	(b)	Total No. of Defective teeth	U.R. 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 U.L.
	(c)	Total No. of Dental Point	L.R. 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 L.L.
	(d)	Condition of Gums	Missing teeth to be indicated by Horizontal line (-) and Unsaveable teeth by a cross (x) through the appropriate number	

Remarks

Date

Signature of Dental Officer

FINDINGS OF MEDICAL BOARD / EXAMINATION

Place

Date

Member

Member

Signature of President

FINDINGS OF THE SUBSEQUENT MEDICAL BOARD/EXAMINATION

Place

Date

Member

Member

Signature of President

APPROVING AUTHORITY

(where applicable)

Place

Date

Signature

Rank & Designation