Western Hospitality Institute
4 Humber Avenue, Montego Bay
St. James, Jamaica W.I.
Tel/Fax: (876)953-0810 Cell: (876) 584-5850
Email: whi_registrar@yahoo.com

PART 1 MEDICAL HISTORY (To be completed by student)

Name of Student (Full Caps):	**Date of Birth:** --------/--------/-------- MM DD YY

(1) When was the last time you did a medical? _____

(2) Have you ever been admitted to a hospital before? Yes [ ] No [ ]
Explain: _____

(3) Are you currently on medication? Yes [ ] No [ ]
Explain: _____

(4) How many alcoholic drinks you have weekly _____, daily _____, other _____?

(5) Do you have asthma, diabetes or blood pressure problems? Yes [ ] No [ ]
Explain: _____
_____

(6) Do you have allergies? Yes [ ] No [ ]
Explain:_____
_____

(7) Do you have frequent bouts of headache? Yes [ ] No [ ]
Explain:_____
_____

(8) Have you ever done X- Ray, ECG or any other tests? Yes [ ] No [ ]
Explain:_____
_____

(9) Have you ever done surgery? Yes [ ] No [ ]
Explain: _____

(10) Are you allergic to aspirin____ or pennicilin____?

(11) Do you have any other medical condition not mentioned above? Yes [ ] No [ ]
Explain:_____
_____

PART 2 MEDICAL EXAMINATION (To be completed by Physician)

(1) Height _____ Weight _____

(2) Blood pressure reading

	1	2	3
Systolic:	_____	_____	_____
Diastolic:	_____	_____	_____

(3) **Urinalysis:**
Sugar _____, Blood _____, Albumin _____, Other _____

(4) **Heart:**
Enlargement Yes [ ] No [ ] Dyspnea Yes [ ] No [ ] Edema Yes [ ] No [ ]

(5) **Pulse:**

	At rest	After Exercise	3 minutes later
Rate:	_____	_____	_____

(6) Is there any abnormality in any of the following?

	Yes	**No**	**Explain**
(a) Eyes, ears, nose, throat	[ ]	[ ]	_____
(b) Skin, moles and veins	[ ]	[ ]	_____
(c) Respiratory system	[ ]	[ ]	_____
(d) Musculo skeletal system	[ ]	[ ]	_____
(e) Nervous system	[ ]	[ ]	_____
(f) Endocrine system	[ ]	[ ]	_____

(7) Reason/symptoms Diagnosis, medication given, tests done and results

_____
_____
_____

I certify that I have made a thorough physical examination of _____, and that the answers given are a true picture of the exam.

Signed at _____ on the _____ day of _____ 20 ____.

Print name (Full caps): _____
Medical Qualifications: _____
University: _____

Medical examiner's signature: _____
Contact number(s): _____
Address: _____
_____

Please affix stamp/seal in the box.