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|---|--------|
| 10. Chest complaint (if yes, give details) | Yes/No |
| 11. Diabetes | Yes/No |
| 12. Hypertension | Yes/No |
| 13. Asthma | Yes/No |
| 14. Discharge from ear or deafness | Yes/No |
| 15. Leprosy | Yes/No |
| 16. Insanity, Mental instability
Nervous breakdown or Disorder | Yes/No |
| 17. Epilepsy or Fits | Yes/No |
| 18. Any other serious or chronic disease (If yes, details please) | Yes/No |

(II) Have you met any serious accident or personal injury or have had a surgical operation. Yes/No (If yes, details please) _____

(III) What is the present state of your health?

(IV) L.N.M.P. _____

(V) Are you predisposed to any complaint? Yes/No (If yes, details please) _____

C. State the following particulars regarding your parents:

If Living			If Dead	
	Age	State of Health	Age	Cause of Death
Father				
Mother				