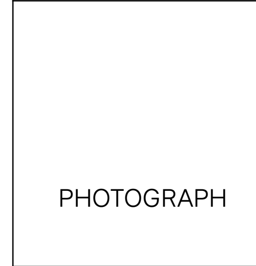
REGISTRATION FORM FOR HEALTH RUN

PATIENT / STUDENT / HEALTHY RUNNER /VOLUNTEER/ DOCTOR. DATE : ________________________

NAME


PHOTOGRAPH

:____

AGE/SEX :____

WEIGHT : _______ HEIGHT : ________ BMI : ________

ADDRESS :____

____

CONTACT NO.
:____

RELATIVE CONTACT NO.
:____

MEDICAL HISTORY [FOR PATIENTS , TO BE FILLED BY DOCTOR]

K/C/O : DIABETES /HYPERTENSION/ DYSLIPIDEMIA /ASTHMA/ TB/COPD/HYPOTHYROID/HYPERTHYRIOD/IHD/

SX /H/O
:____

TREATMENT HISTORY
:____

LAST MONTH ANY SIGNIFICANT HISTORY
:____

ON EXAMINATION :

AT REST :

PULSE - __________ TEMP : ____________ SPO2- ______________

BP- ______________ RR : _____________ RBS -_________________

AFTER 6 MINS WALK :

PULSE - __________ TEMP - ___________ SPO2 – ____________________

BP- ______________ RR- ______________ RBS(FOR DIABETIC) – _______

ADVICE
:____

FIT FOR THE HEALTH RUN : _______________________ _KMS.

DOCTOR SIGN :

THIS FORM IS TO BE SUBMITTED AT TWIN CITY MULTISPECIALITY CLINIC, 1 ST FLOOR BREEZE VIEW COMPLEX , BREEZE VIEW COMPLEX, ABOVE CANARA BANK , KOPARLI ROAD, VAPI

REGISTRATION FEES : 250 RPS FOR PATIENT, 300 RPS FOR STUDENTS , 400 RPS FOR HEALTHY RUNNERS

FOR STUDENTS : AGE SHOULD BE ABOVE 15 YRS , ID CARD IS NECESSARY.

FOR MORE DETAILS CONTACT N0 : 9714738883 /8980937665 /7405393598