

CERTIFICATE OF HEALTH

Name : _____
(Family name) (First name) (Middle name)

Sex : Male Female Date of Birth : _____

Present Address : _____

1) Height : _____ cm Weight : _____ kg

2) Blood Pressure : _____ / _____ mmHg

3) Blood type (optional):

4) Visual acuity : (R) _____ (L) _____ [(R) _____ (L) _____]
without glasses [with glasses or contact lenses]

5) Hearing : (R) Normal Abnormal
(L) Normal Abnormal

6) History of past illness : (Please indicate , if any.)

7) Present condition of health : (If you find any disease or physical abnormality,
please describe in detail.)

8) The applicant's health and physical condition : (Please check)

Examination Good Fair Poor

Date of Examination : _____

Signature : _____

Name and title of doctor/physician (Please print) :

Institution and address :
