World Medical Hospital (WMC)
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Patient Enrollment Form

Introduction:

First Name: _____ Last Name: _____

Date of Birth: _____ Age: _____

Weight: _____ kg Height: _____ cm

Passport Number: _____ NID/Birth Registration Number: _____

Phone Number: _____ Email Address: _____

Residential Address: _____

Previous History:

Are you suffering from any of the following deaseases?

Hypertension Heart Deseases Kidney Thyroide

Others (Specify): _____

Not Known

Do you have any allergies ?

Cold

Dust

Food (Specify) _____

Medicine (Specify) _____

Others (Specify) _____

Not Known

Do you have ever gone through any surgery ?

No

Yes (Specify) _____

Is there any Genetical Desease/ Familial Deasease history ?

No

If Yes, Specify

Relation: _____ Name of the deasease: _____

Relation: _____ Name of the deasease: _____

Do you intake alcohole ?

Yes No

Do you have Smoking Habit?

Yes No

Do you want to mention anything about your previous medical history other than your current problem ?

Current Problem:

Symptoms: _____

Prolem descriotion: