INSTITUTE OF HOTEL MANAGEMENT, PUSA, NEW DELHI

MEDICAL HISTORY

(To be filled in by student): Blood Group ___________

Name of Student: Roll No. /AIR No. :	Address :		
Parent's Name & contact no.:		Previous Organization / Institute:	
Name & contact no. of family doctor:			
Date of Birth:	Age on 01/07/2024 :	Place of Birth:	Citizenship:
GENDER	**MARITAL STATUS**	**(√ CHECK APPROPRIATE BOXES)**	
❑ Female ❑ Male	❑ Single ❑ Married	❑ Widowed ❑ Separated	❑ Divorced

FAMILY HISTORY

Member of Family	LIVING		DECEASED	
	Age	Health	Age	Cause of Death
Father				
Mother				

Disease Check Yes/No	Yes	No	Member of Family	Disease Check Yes/No	Yes	No	Member of Family
Tuberculosis							
Cancer							
Diabetes							
Epilepsy							

Comments ____

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PAST HISTORY AND PRESENT ILLNESS (CHECK YES OR NO)

Have you ever Had	**Yes**	**No**	**Year**	**Have you ever had**	**Yes**	**No**	**Year**
Eye Problem				Hemorrhoids/Piles			
Ear Problem				Diabetes			
Migraine Headaches				Cancer/Tumors			
Coughing up Blood				Anemia(Blood deficiency)			
Thyroid Problems				Sexually Transmitted Disease			
Rheumatic Fever				Arthritis			
Palpitations				Surgical Operations			
High Blood Pressure				Skin Problems			
Chest Pain				Major Injury			
Fainting-Dizzy Spells				Food Intolerance			
Frequent Stomach upsets				Tuberculosis (T.B.)			
Ulcers/Acidity				Mental Disorders			
Hepatitis/ Jaundice				Allergy to any to any Medicine			
Malaria				Depression			
Kidney Stones				Vaccination - Typhoid			
Urine infections				Vaccination – Hepatitis A			
Prostate Problems				Vaccination – Hepatitis B			
Weight Loss/Gain in last Year				Covid 19- Vaccination			

Do You Yes No

Smoke ☐ ☐ Amount Per Day
____

☐ ☐

Drink Alcohol ☐ ☐ Amount Per
Week____________________

Wear glasses or contact lenses Lens Power L_______ R
____

I, hereby declare that I fully understand that IHM Pusa doesn't have any full time Medical Practitioner/Associate at the premises and won't be able to give any specialized treatment in case my ward is suffering from any pre-existing serious medical condition mandating immediate medical attention.

I acknowledge that while the Institute strives to offer the best possible first aid, there may be unforeseen circumstances that could arise in these cases. I understand that the institute and its staff are not liable for any situation arising out of wilful suppression of pre-existing condition by me resulting in injury.

By signing this declaration, I agree to release and hold harmless IHM Pusa, its officers and employees from any and all claims, demands, damages, or liabilities that may arise as a result of any mishap or medical issue that occurs during my ward's time at the Institute. I have read and understood the terms of this declaration and accept them voluntarily.

Also I certify that the information stated in the form is correct to the best of my knowledge and belief. If at any time, it is proven that such medical information was willfully suppressed /withheld by me, I accept the liability of my ward's expulsion.

DATE: ________________

PLACE : _______________ **SIGNATURE AND NAME OF BOTH PARENTS**