Health fitness certificate format for Certification as Yoga Professional

PRE- Certification HEALTH CHECK UP

Name:

Age:

Gender:

Cell Phone Number

E-mail ID

The afore mentioned is has underwent pre-certification health check at ……. HOSPITAL, ……. He / She found to have following diagnosis ……..

Recommended / Not recommended to work as Yoga Professional

This is valid for 1 year from the day of issue of this form.

Signature of the Medical Officer

Date

Signature of the Yoga Professional

MEDICAL EXAMINATION FORM

Name:		Post / Designation:				DOB:	
GENERAL EXAMINATION							
Identification Mark:						Date of Examination:	
Height:	Weight:	Pulse per minute:					
Chest expansion:		Inspiration:				Expiration:	
Family History:							
History of past illness:				Major Minor			
Present aliment being treated:		For		At		By	
Last Surgery undertaken		For		At		By	
Protected against Typhoid/ Cholera			Yes/No	If yes, when			
Eyes:	Vision with Glasses		Rt Lt	Vision w/o glasses		Rt Lt	
E.N.T							
C.N.S							
Lungs							
Heart							
Hernia				Hydrocele:			
Blood Pressure	Systolic:			Diastolic:			
*Urine: S.Gravity:	Sugar:		Color:		Albumin:		
*M.M.R. or X-ray of Chest:							
*Blood	E.S.R.		HB		Group		
*Limbs	Normal		Not Normal		Type		
*Above 40 years	ECG	Normal		Not normal		Type	
*Above 40 years	Blood Cholesterol		Reading				
*Above 40 years	Fasting Blood Sugar		Reading				
*Any Allergic Experience:							
Final remarks of the Medical Officer: _____ Signature of the Medical Officer							

*Examination Reports should be attached.

PRE-MEDICAL HISTORY INFORMATION / DECLARATION

NAME			
DATE OF BIRTH			
		LOCATION	

		YES / NO
1	Do you have any family history of:	
	a) Heart ailment	
	b) Diabetes	
	c) Mental illness	
	d) Tuberculosis	
2	Whether you have undergone any surgical operation in the past?	
3	Do you take medicines regularly?	
4	Do you have any body deformity or defect?	
5	Do you have any problem of Rheumatism / Asthma / Joint pain?	
6	Do you have any large veins in your legs, thighs (varicose -veins)?	
7	Are you color blind?	
8	Do you have any hearing problem?	
9	Have you ever had any skin disorder?	
10	Have you ever had medical treatment for?	
	a) Allergies	
	b) Hay fever	
	c) Reaction to surgery	
	d) Reaction to medicine	
	e) Sprain	
	f) Fracture or broken bone	
	g) Diabetes	
	h) Fits	
	i) Eye trouble	
	j) Fainting spells	
	k) Heart troubles or High Blood Pressure	
	l) Hernia or Rupture	
	m) Injury to knee joints	
	n) Paralysis or weakness in arms or legs	
	0) Emotional upsets	
	p) Tuberculosis	
	q) Rheumatism	
	r) Prolonged fever	
	s) Back pain	
	t) Sacroiliac	
	u) Any other health condition	

I hereby certify the above information to be correct

NAME **Signature**