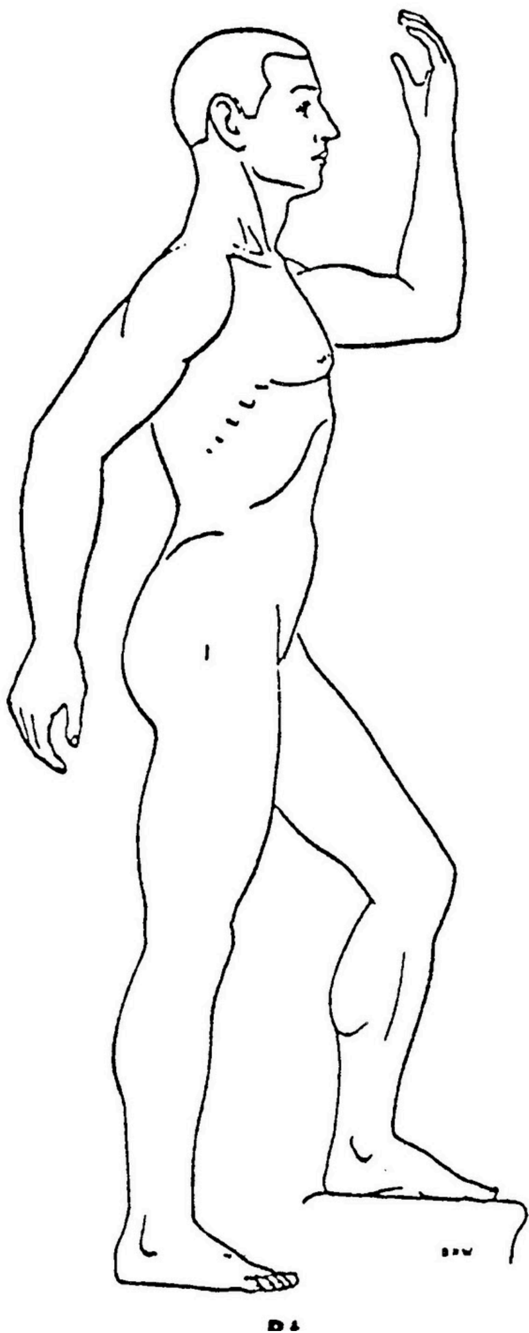
Republic of the Philippines
City Government of Antipolo
ANTIPOLO CITY HOSPITAL SYSTEM - ANNEX

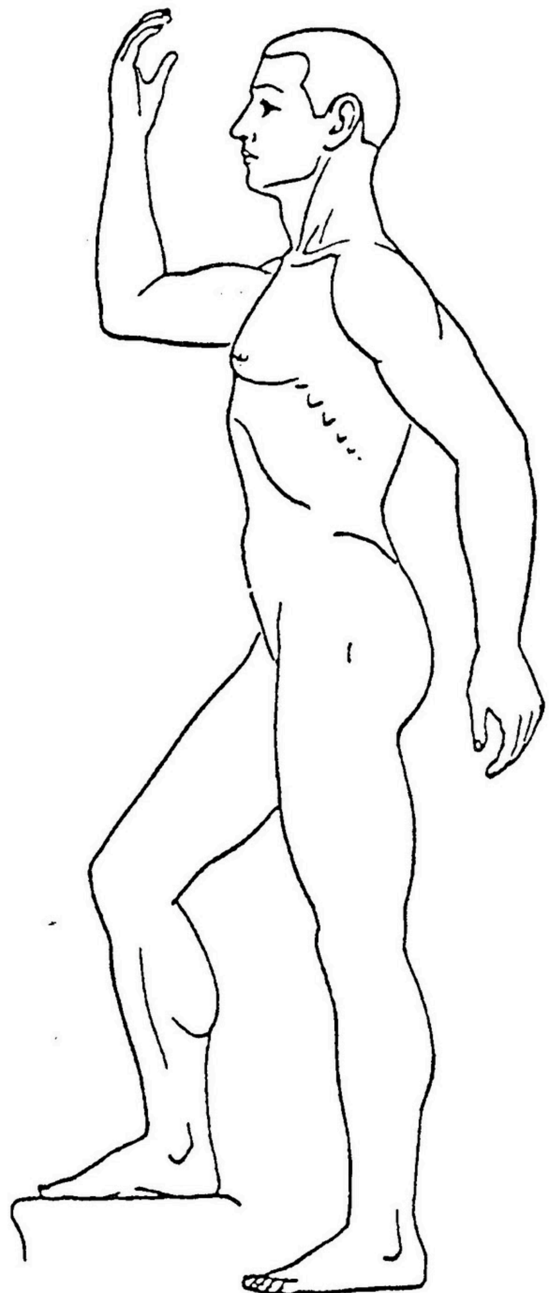
Control No. ________________
ML No. ____________________
Date: _____________________

Last name: _________________ First Name: ____________________ Middle Name: _________________

Sex: [] Male. [] Female Age: __________

Date of examination: ______________________ __________ A.M. __________ P.M.





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Name and Signature of Examining physician