



# MEDICAL HISTORY & EXAMINATION

Applicant: As part of your application process, it is necessary for you (and your spouse and child/ren, if married) to complete this history. Please ensure that the information is **complete** and **accurate**.

Full Name: \_\_\_\_\_ Date of Birth: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

**I. HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING? Check [✓] the appropriate box.**

Yes	No	Relation	Yes	No	Relation	Yes	No	Relation
		Tuberculosis			Diabetes			Arthritis, Rheumatism
		Glaucoma			Kidney Trouble			Asthma, Hives, Hay Fever
		Cancer			Migraine Headaches			Epilepsy
(list type of cancer)					High Blood Pressure			Committed Suicide

**II. HAVE YOU EVER HAD, BEEN TREATED FOR, OR CONSULTED A PHYSICIAN FOR THE FOLLOWING PROBLEMS? Check [✓] the appropriate box. Give full details for each "Yes" answer in section III at the bottom of this page. Add an extra page if needed.**

Yes	No	Yes	No	Yes	No
		Heart Trouble			Digestive Disorder
		Heart Murmur			Intestinal Disorder
		Rheumatic Fever			Hepatitis
		Chest Pain			Cirrhosis
		Stroke			Other Liver Trouble
		High Blood Pressure			Kidney Stone or Infection
		Abnormal Pulse			Bladder Stone or Infection
		Hardening of the Arteries			Prostate Trouble
		Diabetes			Sugar, Albumin, Blood or Pus in Urine
		Thyroid or Other Gland Problem			Psychiatric Problem
		Blood Disorder			Emotional Problem
		Asthma			Nervous Problem
		Bronchitis			Epilepsy
		Tuberculosis			Convulsion
		Other Lung Disorder			Dizziness
		Ulcer			Loss of Consciousness
		Gall Bladder Disease			Frequent Headaches
		Colitis			Other Nervous System Disorder
		Internal Bleeding			Cancer
					Tumor
					Cyst
					Skin Disorder
					Recurring Allergy
					Hernia
					Hemorrhoids
					Varicose Veins
					Circulatory Disorder
					Arthritis
					Rheumatism
					Sciatica (acute pain in the hip and thigh due to sciatic nerve)
					Gout
					Deformity
					Amputation
					Disease of Eyes
					Disease of Ears
					Disease of Nose
					Disease of Throat

III. FULL DETAILS FOR EACH "YES:"	Onset Year	Recovery Year
Identify each problem listed above, describing the nature and severity of the condition. Include frequency, treatment, medication, surgery, results, onset year, and recovery year.		



**IV. HAVE YOU EVER HAD THE FOLLOWING?** Check [✓] the appropriate box. Give full details for each "Yes" answer in section V at the bottom of the page. Add an additional page if needed.

Yes	No		Yes	No		Yes	No	
		General:			Breasts:			Genital/Urinary System: (Cont'd)
		Tire easily, weakness			Soreness			Increase in frequency of urination (night)
		Marked weight loss			Lumps			Feel need to urinate without much Urine
		Night Sweats			Discharge			Inability to hold urine
		Persistent Fever			Cardio-Respiratory System:			Pain or burning
		Advice or treatment for use of alcohol or narcotics			Cough, persisting			Blood in urine
		other drugs (LSD)			Sputum (phlegm)			Lack of sex drive
		Do you smoke?			Bloody sputum			Menstrual disorder
		Frequent use of any medication			Wheezing			Disabling, painful menses
		Any hospitalizations?			Chest pain or discomfort			Pregnancy
		Any surgery?			Pain on breathing			Abortion/Miscarriage
		Skin:			Shortness of breath			Endocrine: (Glands)
		Eruptions (rash)			Difficulty breathing while lying down			Thyroid trouble
		Eyes:			Swelling of ankles			Adrenal trouble
		Trouble seeing			Bluish fingers or lips			Cortisone treatment
		Eye pain			High blood pressures			Diabetes
		Inflamed eyes			Palpitations			Hypoglycemia
		Double vision			Vein trouble			Muscle/Joint System:
		Need for glasses			Digestive system:			Muscle cramps
		Ears:			Belching or excess gas			Muscle spasms
		Loss of hearing			Change in appetite			Muscle weakness
		ringing in ears			Difficulty in swallowing			Pain in joints
		Discharge			Heartburn			Swollen joints
		Nose:			Abdominal distress			Stiffness
		Loss of smell			Abdominal enlargement			Heat in joints
		Frequent colds			Nausea			Nervous system:
		Obstruction			Vomiting			Headaches
		Excess of discharge			Vomiting of blood			Dizziness
		Nosebleeds			Rectal bleeding			Fainting
		Mouth:			Tarry stools			Convulsions or fits
		Sore gums			Jaundice			Nervousness
		Soreness of tongue			Constipation			Sleeplessness
		Dental Problems			Diarrhea			Depression
		Throat:			Hemorrhoids			Memory loss
		Post-nasal drainage			Need for laxatives			Poor coordination
		Soreness			Genital/Urinary system:			Weakness or paralysis of muscles
		Hoarseness			Increase in frequency of urination (day)			

V. FULL DETAILS FOR EACH "YES:"	Onset Year	Recovery Year
Identify each problem listed above, describing the nature and severity of the condition. Include frequency, treatment, medication, surgery, results, onset year and recovery year.		



### MEDICAL EXAMINATION

This portion should be accomplished by a licensed physician. Complete your medical history form AND have your laboratory tests done first before going to the doctor for your medical examination. Show both your medical history and laboratory reports to the doctor then have him or her fill up this medical examination form.

Date of exam: _____	Build: (circle)	BP: _____	Any extra systoles? ____
Measurements:	underweight	heavy	Pulse at rest: _____
Ht: ____ ft ____ in	medium	obese	Pulse after exercise: _____
Wt: _____ kg			Pulse 5 minutes later: _____

Please examine and check (✓) each area:

	Normal	Abnormal
Ears:		
Eyes:		
Nose:		
Throat:		
Neck:		
Breasts:		
Heart:		
Lungs:		
Abdomen:		
Genitalia:		
Pelvic (Pap required – female):		
Rectal (required):		
Extremities:		
Spine:		
Skin:		
Glands:		

#### LABORATORY

Requirements include:

Complete Blood Count

Chest X-ray

Fecalysis

Urinalysis

Please attach original copies of recent lab reports. Do not send X-ray film by mail.

If the original laboratory reports are notarized translation into English. See lab reports.

Comments on laboratory reports:

Comments on overall health:

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE OVER PRINTED NAME

\_\_\_\_\_  
DATE