MEDICAL HISTORY

(To be filled and submitted to the examining physician before the physical examination)

Name_____ Date_____ Birth date _____

Home Address _____ Birthplace _____ Nationality: _____ Single _____ Married _____ Widowed _____

Countries where you have resided. Give dates. _____

Assignment country and type of work. _____

Particular concerns on return from assignment: _____

Note special health risks e.g. Malaria; TB; HIV; Parasites; High stress; Travel risks

Evaluation of present health status: Excellent___ Good_____ Fair_____ Poor_____

Have you had or do you now have:

	Yes	No		Yes	No		Yes	No		Yes	No
Frequent head colds			Poor appetite			Shortness of breath			Lack of self-confidence		
Frequent chest colds			Discomfort after meals			Heart Pounding			Sleeplessness		
Frequent sore throats			Frequent nausea-vomiting			Chest pain			Panic attacks		
Frequent nose bleeds			Frequent diarrhea			Skin trouble			Headaches		
Frequent cough			Blood in stools			Excessive perspiration			Dizziness		
Visual difficulties			Abdominal pain			Recent weight loss/gain			Thyroid disturbances		
Frequent earaches			Frequent urination			Joint pains			Fever		
Draining ears			Painful urination			Inability to concentrate			Anemia		
Any deafness			Easy fatigue			Anxiety depression			Eyestrain		

Past Medical History: (Give approximate age at which you had any of the following diseases. State whether severe (S), moderate (M) or light case (L). Give dates when you were last immunized (e.g. Aug. 1995)

German Measles _____ Poliomyelitis _____ Heart trouble _____ Nervous Breakdown _____

Measles _____ Influenza _____ High Blood pressure _____ Epilepsy _____

Mumps _____ Pneumonia _____ Hay Fever _____ Venereal Disease _____

Chickenpox _____ Tuberculosis _____ Asthma _____ Jaundice _____

Whooping Cough _____ Undulant Fever _____ Diabetes _____ Dysentery _____

Diphtheria _____ Pleurisy _____ Stomach Trouble _____ Tendency to bleed _____

Scarlet Fever _____ Rheumatic Fever _____ Appendicitis _____ Infectious Mononucleosis _____

Typhoid Fever _____ Tonsillitis _____ Hernia (rupture) _____ Hemorrhoids (Piles) _____

Malaria _____ Discharging ears _____ Colitis _____

Small pox _____ Sinus Trouble _____ Kidney Trouble _____

Operations (Dates) _____ Tonsillectomy? _____

Injuries (Dates) _____ Blood Type _____ Blood transfusions? _____

Medications being taken: _____ Other Illnesses _____

Allergies to Medications: _____ Other known allergies: _____

Vitamin Supplements _____ Alternatives being used? _____

Prior use of alcohol, cigarettes, recreational drugs _____ Known exposure to HIV risk _____

Family History:

My father has Good Fair Poor Health, Is Thin ___average ___obese___ Died of _____age_____

My mother has Good Fair Poor Health, Is Thin ___average ___obese___ Died of _____age_____

Brothers & sisters Living B_____ S_____; Health _____

Dead B_____ S_____; Died of _____age_____

Check conditions blood relatives have had: (e.g. Tuberculosis: Uncle F__ Uncle Father's family)

High Blood Pressure _____ Diabetes _____ Epilepsy _____ Nervousness _____

Heart Disease _____ Hay Fever, Asthma _____ Jaundice _____ Nervous Breakdown _____

Stroke (Apoplexy) _____ Cancer _____ Migraine (sick headache) _____ Other _____

Kidney Disease _____ Tuberculosis _____ Tendency to bleed _____ _____

Women check:

Menstruation: Age at onset _____; Periods regular every _____days; irregular _____; Duration _____days.

Amount, small _____ medium _____ profuse _____ ; Character of pain: Cramping _____ Dull _____ (mild/moderate/severe)

Pregnancies _____ Dates of delivery _____ Any complications _____

Present or past treatment for female disorders? If so, what _____

(Over 45) pre menopausal symptoms; _____ Hormone Replacement yes____ no_____

PLEASE USE OTHER SIDE OF PAGE IF MORE SPACE IS NEEDED

PHYSICIAN'S EXAMINATION

This examination must be made by a physician holding an M.D./D.O. degree

Name _____ **Age** _____ **Blood Type** _____

Height ____in Weight ___lbs Waist _____in Chest _____in Resp. _____ Pulse _____/min B.P. _____

Region	Normal	Abnormal	Explanatory Note
Eyes-Visual Acuity-R			
-L			
Ophthalmoscopy-R			
-L			
Pupils (L and A)			
Lids			
E.O. Muscles			
Ears – Hearing			
Canals			
Drums			
Nose & Throat – Gums			
Dental Repair			
Tongue			
Pharynx			
Other			
Neck – Thyroid			
Other			
Chest – Inspection			
Pulmonary Findings			
Breasts			
Axillary Nodes			
Heart – Size			
Rhythm			
Murmurs			
Functional capacity			
Abdomen – Scars			
Tenderness			
Masses			
Liver			
Spleen			
Kidney			
Genitalia – Hernia			
External			
Male – Prostate			
Female – Perineum			
Cervix			
Uterus			
Adnexa			
Discharge			
Anorectal			
Pilonidal Cyst			
Other			
Orthopedics			
Posture/Gait			
Spine			
Arms			
Hands			
Legs			
Feet			
Joints – swelling			
Tenderness			
Limit in range of motion			

Region	Normal	Abnormal	Explanatory Note
Neuro – reflexes			
Sensation			
Co-ordination			
Skin Condition			
Nails			
Hair			
Emotional Stability			
Sleep Patterns			
Appetite			
Evidences of Psychiatric disorders			
Nervous Condition-Tics			
Tremor			
Motor Paralyses			
Endocrine			
Development			
Function			

Laboratory Examinations		Other
Urine: Sugar	Albumin	Drug Test (panel 4)
Sp. Grav.	Micro.	
Blood: cbc /Diff	Comp Metab. Panel	Last PAP
Lipid Panel	TSH	Date Result
PSA (men over 50)	Hepatitis panel	Mammo (over 45)
Type	Parasites	EKG (all over 50)
Stools – haem; ova	HIV	
Chest X-Ray	Blood Type (if unknown)	

SUMMARY OF FINDINGS

Health status is: Excellent_____ Very Good_____ Good_____ Poor_____ Very Poor_____

Current Proven or Suspected Diagnoses not stated on Medical Summary Sheet

Diagnosis	Under Treatment?
	Yes___ No___ Not indicated____
	Yes___ No___ Not indicated____
	Yes___ No___ Not indicated____

RECOMMENDATIONS (Please Check One)

(1) In My opinion this patient may proceed to assignment overseas θ

(2) Dental Evaluation advised. Date _____ θ

(3) Ophthalmic Evaluation as indicated _____ _____ θ

(4) The health status of this patient warrants careful review by the SCS Medical Advisor θ
(Please outline reasons on the other side.)

Signature: _____ License no: _____

Name: _____ Date: _____

Address: _____