Medical Screening Report

Name of Applicant: _____

Address: _____

_____

Phone Contact: _____

Email Address: _____

Gender: ☐ **Male** ☐ **Female**

Date of Birth: _____ **Age:** _____

Nationality: _____ **Place of Birth:** _____

Ethnicity: _____

	Applicant		
SPECIFIC MEDICAL CONDITIONS:	**YES**	**NO**	**N/A**
High Blood Pressure			
Diabetes			
Heart Disease (ongenital or otherwise)			
Seizures/Epilepsy			
Asthma			
Blood Disorder(s)			
Cancer(s)			
Infertility			
Miscarriages			
Psychiatric Illnesses			
Other (please specify in comments below)			

For any of the above conditions, please elaborate (include diagnostic information and management of condition): _____

_____

_____

_____

Outpatient Clinic: ☐ **Yes** ☐ **No**

Where: _____

Last Visit: _____

Next Visit: _____

Medications: _____

_____

_____

_____

Comments: _____

_____

_____

Allergies: _____

_____

_____

Surgeries: _____

_____

Family Medical History: _____

_____

_____

_____

Family Psychiatric History: _____

_____

_____

Social History (includes lifestyle habits, diet, & physical activity): _____

_____

_____

DRUG	YES	NO	FREQUENCY	LAST USE	COMMENTS
Alcohol					
Tobacco					
Cocaine					
Marijuana					
Analgesics (E.g. morphine, codeine)					
Other Medications not prescribed by Doctor/Not used to treat a specific medical condition					
Other Substances					

Physical Examination

Weight: _____(kg)

Height: _____ (cm)

BMI: _____

Vital Signs

BP: _____ (mmHg) **Temperature:** _____ (^{0}C)

HR: _____ (bpm) **RR:** _____ (bpm)

Cardiovascular: _____

Neurologic: _____

Respiratory: _____

Abdominal: _____

Genitourinary: _____

Head and Neck: _____

Eyes: _____

ENT: _____

Skin: _____

Lymphatic: _____

Musculoskeletal: _____

SUMMARY: _____

_____

_____

_____

BLOOD INVESTIGATIONS

1) **HIV**
2) **DRUG SCREEN: Cocaine, THC**

RECOMMENDATIONS: _____

_____

_____

_____

Name of Examining Doctor (block letters): _____

Signature: _____

Name of Attending Nurse (block letters): _____

Signature: _____

Date and Time of Completion of Medical Evaluation: _____