

CONFIDENTIAL	<b>ENTRY MEDICAL EXAMINATION FOR FELLOWSHIP CANDIDATES</b>		<b>UNITED NATIONS AND SPECIALIZED AGENCIES</b>
--------------	--	---	--

I hereby authorize any of the doctors, hospitals or clinics mentioned in this form to provide the United Nations Medical Service with copies of all my medical records so that the Organization can take action upon my application for fellowship.

I certify that the statements made by me in answer to the questions below are, to the best of my knowledge, true, complete and correct. I realize that any incorrect statement or material omission in the medical information form or in any other document required by the Organization renders a fellow liable to termination.

Date: ..... Signature: .....

*Pages 1 and 2 are to be completed by the candidate*

FAMILY NAME (IN BLOCK CAPITALS)		GIVEN NAMES	MAIDEN NAME (FOR WOMEN ONLY)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
ADDRESS (STREET, TOWN, DISTRICT OR PROVINCE, COUNTRY)			DATE OF BIRTH	NATIONALITY
FELLOWSHIP APPLIED FOR (DESCRIBE NATURE OF STUDY)		TELEPHONE	BIRTHPLACE	
DUTY STATION		PRESENT MARITAL STATUS		
		Married <input type="checkbox"/> DATE: .....	Single <input type="checkbox"/>	Divorced <input type="checkbox"/> DATE: .....
		Separated <input type="checkbox"/> DATE: .....	Widowed <input type="checkbox"/> DATE: .....	

Have you ever undergone a medical examination for the United Nations or one of its agencies? .....

Have you ever been employed by the United Nations or one of its agencies? .....

If so, please state when, where and for which Organization: .....

**FAMILY HISTORY**

Relative	Age (if still alive)	State of Health (If still alive, present state; if deceased, cause of death)	Age at death	Have members of your family had the following illnesses or disorders?	Yes	No	Who?
Father				High Blood Pressure			
Mother				Heart Disease			
Brothers				Diabetes			
Sisters				Tuberculosis			
Spouse				Asthma			
Children				Cancer			
				Epilepsy			
				Mental Disorders			
				Paralysis			

<b>TO BE COMPLETED BY THE OFFICIAL REQUESTING THE MEDICAL EXAMINATION</b>	<b>TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE</b>
Name of Official: .....	Medical Classification: <span style="border: 1px solid black; padding: 2px;">1a</span> <span style="border: 1px solid black; padding: 2px;">1b</span> <span style="border: 1px solid black; padding: 2px;">2a</span> <span style="border: 1px solid black; padding: 2px;">2b</span>
Department or Unit: .....	Comments: .....
Date: .....	Date: ..... Signature: .....

**VERY IMPORTANT:** Please indicate the recruiting Agency or Organization:

*Each question requires a specific answer (yes, no, date, etc.); to leave a blank or draw a line is not sufficient. If the questionnaire is not fully completed and enquiries are therefore needed, time may be lost.*

1. Have you suffered from any of the following diseases or disorders? Check yes or no. If yes, state the year.

	YES Date	NO		YES Date	NO		YES Date	NO		YES Date	NO
Frequent sore throats			Heart and blood vessel disease			Urinary disorder			Fainting spells		
Hay fever			Pains in the heart region			Kidney trouble			Epilepsy		
Asthma			Varicose veins			Kidney stones			Diabetes		
Tuberculosis			Frequent indigestion			Back pain			Gonorrhoea		
Pneumonia			Ulcer of stomach or duodenum			Joint problems			Any other sexually transmitted disease		
Pleurisy			Jaundice			Skin disease			Tropical disease		
Repeated bronchitis			Gall stones			Sleeplessness			Amoebic dysentery		
Rheumatic fever			Hernia			Any nervous or mental disorder			Malaria		
High blood pressure			Haemorrhoids			Frequent headache					

2. Are you being treated for any condition now? \_\_\_\_\_ Describe: \_\_\_\_\_

3. Have you ever coughed up blood? \_\_\_\_\_

4. Have you ever noticed blood in your stools? \_\_\_\_\_ In your urine? \_\_\_\_\_ Give details: \_\_\_\_\_

5. Have you ever been hospitalized (hospital, clinic, etc.)? \_\_\_\_\_  
Why, where and when? \_\_\_\_\_

6. Have you ever been absent from work for longer than one month through illness? \_\_\_\_\_ If so, when? \_\_\_\_\_  
And for what illness? \_\_\_\_\_

7. Have you had any accidents as a result of which you are partially disabled? \_\_\_\_\_ If so, what and when? \_\_\_\_\_  
Do you have any other disability? \_\_\_\_\_

8. Have you ever consulted a neurologist, a psychiatrist or a psychoanalyst? \_\_\_\_\_  
If so, please give his/her name and address: \_\_\_\_\_  
For what reason? \_\_\_\_\_ Date of the consultation: \_\_\_\_\_

9. Are you taking any medicine regularly? \_\_\_\_\_ If so, which? \_\_\_\_\_

10. Have you gained or lost weight during the last three years? \_\_\_\_\_ If so, how much? \_\_\_\_\_

11. Have you ever been refused life insurance? \_\_\_\_\_ If so, state reason: \_\_\_\_\_

12. Have you ever been refused employment on health grounds? \_\_\_\_\_ If so, state reason: \_\_\_\_\_

13. Have you ever received or applied for a pension or compensation for any permanent disability? \_\_\_\_\_ Degree? \_\_\_\_\_  
Please give details: \_\_\_\_\_

14. Have you ever stayed in a tropical country? \_\_\_\_\_ If so, for how long? \_\_\_\_\_

15. Have you in the past suffered from any condition which prevented travel by air? \_\_\_\_\_

16. Do you consider yourself to be in good health? \_\_\_\_\_ Do you have full work capacity? \_\_\_\_\_

17. Do you smoke regularly?  Yes  No If so, what do you smoke?  Cigarettes  Pipe  Cigars  
For how many years have you smoked? \_\_\_\_\_ How much per day? \_\_\_\_\_

18. Daily consumption of alcoholic beverages: \_\_\_\_\_

19. Has any doctor or dentist advised you to undergo medical or surgical treatment in the foreseeable future? \_\_\_\_\_  
Give details: \_\_\_\_\_

20. Give any other significant information concerning your health: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. What is your occupation? \_\_\_\_\_ Indicate the last three posts you have occupied: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. List any occupational or other hazards to which you have been exposed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Have you been rejected for military service for medical reasons? \_\_\_\_\_

24. **FOR WOMEN** Are your periods regular?  Yes  No  
Are they painful?  Yes  No  
Do you have to stay in bed when they come?  Yes  No  
If so, for how long? \_\_\_\_\_ Date of your last period: \_\_\_\_\_

Do you take contraceptive pills?  Yes  No If so, for how many years have you been doing so? \_\_\_\_\_ Have you ever been treated for a gynaecological complaint?  Yes  No  
If so, which? \_\_\_\_\_

