

CONFIDENTIAL	ENTRY MEDICAL EXAMINATION FOR FELLOWSHIP CANDIDATES		UNITED NATIONS AND SPECIALIZED AGENCIES
---------------------	--	---	--

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
		PRESENT MARITAL STATUS	
DUTY STATION		Married <input type="checkbox"/> DATE: Separated <input type="checkbox"/> DATE:	Single <input type="checkbox"/> Divorced <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			

TO BE COMPLETED BY THE OFFICIAL REQUESTING THE MEDICAL EXAMINATION	TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE
Name of Official:	Medical Classification: 1a 1b 2a 2b
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? _____