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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 ☐ M ☐ 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

Single ☐

Married ☐ DATE: .... Divorced ☐ DATE: ....

Separated ☐ DATE: .... Widowed ☐ 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

Name of Official: ....

Department or Unit: ....

Date:

TO BE COMPLETED BY THE DIRECTOR OF THE MEDICAL SERVICE

Medical Classification: 1a 1b 2a 2b

Comments: ....

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? ____________________

TO BE COMPLETED BY THE EXAMINING PHYSICIAN

GENERAL APPEARANCE

Height: cm. ____________ Weight: kg. ____________

Skin: ______________________________ Scalp : ______________________________

SIGHT, MEASURED VISUAL ACUITY

Gross vision : Right ________ Left ________ Pupils: Equal? ________ Regular? ________

Vision with spectacles : Right ________ Left ________ Fundi (if necessary): ________________

Near vision : Right ________ Left ________ Colour vision: ________________

With correction : Right ________ Left ________

HEARING (test by whispering)

Right : Normal: ________ Sufficient: ________ Insufficient: ________

Left : Normal: ________ Sufficient: ________ Insufficient: ________

Ear drum : Right: ________ Left: ________

NOSE - MOUTH - NECK

Nose : ________ Pharynx: ________ Teeth : ________

Tongue: ________ Tonsils: ________ Thyroid: ________

CARDIOVASCULAR SYSTEM

Pulse rate : ________ Auscultation : ________

Rhythm : ________ Blood pressure : ________

Apex beat : ________ Varicose veins : ________

Peripheral arteries

– carotid : ________

– posterior tibial: ________

– dorsalis pedes: ________

Electrocardiogram (if indicated or after age of 45) – Please attach tracing

RESPIRATORY SYSTEM

Thorax:

Breasts

DIGESTIVE SYSTEM

Abdomen: ________________

Liver : ________________

Spleen: ________________

Hernia: ________________

Rectal examination: ________________

NERVOUS SYSTEM

Pupillary reflexes: – To light: ________ – On accommodation: ________

Patellar reflexes : ________________

Achilles reflexes : ________________

Plantar reflexes : ________________

Motor functions : ________________

Sensory functions : ________________

Muscular tonus : ________________

Romberg's sign : ________________

MENTAL STATE

Appearance:

Behaviour:

GENITO–URINARY SYSTEM

Kidneys:

Genitals:

SKELETAL SYSTEM

Skull : ________________

Spine : ________________

Upper extremities: ________________

Lower extremities: ________________

LYMPHATIC SYSTEM

CHEST X-RAY

(Full size film – Please send film itself, the radiologist's report is not sufficient. Lateral film not necessary unless indicated medically.)

LABORATORY

The results of all the following investigations must be included except where marked "if indicated".

Except by prior agreement, only the investigations mentioned are done at the Organization's expense.

Urine : Albumin ________ Sugar ________ Microscopic ________

Blood : Haemoglobin : ________ % ________ grams/1 Leucocytes: ________

Haematocrit : ________ % ________ Differential count (if indicated): ________

Erythrocytes : ________ Blood sedimentation rate: ________

Blood chemistry (if these tests can be carried out on the spot):

Sugar : ________ Urea or creatinine: ________

Cholesterol : ________ Uric acid : ________

Serological test for syphilis: Please attach laboratory report

Stool examination (if indicated):

COMMENTS (Please comment on all the positive answers given by the candidate and summarize the abnormal findings)

CONCLUSIONS (Please state your opinion on the physical and mental health of the candidate and fitness for the proposed fellowship)

The examining doctor is requested before sending this report to verify that the questionnaire, pages 1 and 2 of this form, has been fully completed by the candidate and that all the results of the investigations required are given on the report. Incomplete reports are a major source of delay in recruitment.

Name of the examining physician (in block capitals):

____

Address: ________

____

____

Signature: ________

Date: ________