# Medical Questionnaire – Part A (to be completed by the attending physician)

Client's name _____ Age _____

Date of Examination _____

## Family Medical History

In the client's family, is there a history of any serious or hereditary disease? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

_____

_____

_____

_____

_____

## Personal Medical History

Has the client suffered from any serious or hereditary disease in the past? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

_____

_____

_____

_____

_____

Is the client currently suffering from any disease? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

_____

_____

_____

_____

_____

**Physical Examination**

Height _____ Weight _____

Musculoskeletal system _____ Nervous system _____

Ears _____ Eyes _____

Nose and neck _____ Oral cavity _____

Thyroid gland _____ Cardiovascular system _____

Blood pressure _____ Respiratory system _____

Stomach _____ Urogenital system _____

_____

HIV test performed on _____ Positive ☐ Negative ☐

Hepatitis C test performed on _____ Positive ☐ Negative ☐

Does the client suffer from any contagious disease, specific disease or disability that could result in a significant risk of transmission? YES ☐ NO ☐

If you have answered YES, please provide a brief explanation: _____

_____

_____

_____

Is the client on any permanent medication? YES ☐ NO ☐

If you have answered YES, please specify the medication: _____

_____

_____

_____

**Assessment of the Overall Health Condition**

The client is healthy ☐

The client is undergoing treatment ☐ (please specify) _____

_____

_____

_____

Have you provided the client with any recommendations on medical care? YES ☐ NO ☐

If you have answered YES, please provide a brief explanation: _____

_____

_____

_____

**Addictions** (drug, alcohol, gambling, etc.)

Has the client undergone treatment in the past? YES ☐ NO ☐ DON'T KNOW ☐

Is the client currently undergoing treatment? YES ☐ NO ☐ DON'T KNOW ☐

If you have answered YES, please specify: _____

_____

_____

Physician's signature and stamp _____

# Medical Questionnaire – Part B (to be completed by the applicant)

1. Are you undergoing treatment for any disease? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

2. Do you suffer from any medical condition or limitation (allergy, asthma, etc.)? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

3. Are you on any permanent medication? YES ☐ NO ☐

If you have answered YES, please specify the medication: _____

_____

4. Do you regularly see a specialist? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

5. In your family (parents, siblings or children), is there a history of any hereditary or serious disease? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

6. What more serious disease have you suffered? _____

_____

7. Have you suffered any serious injury? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

8. Addictions (drug, alcohol, gambling, etc.):

Have your undergone treatment in the past? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

9. Are you currently undergoing treatment? YES ☐ NO ☐

If you have answered YES, please specify: _____

_____

_____

10. From your perspective, do you feel healthy? YES ☐ NO ☐

If you have answered NO, please specify: _____

_____

_____

Date _____ Signature _____