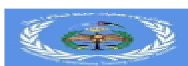

Peace Keeping Operations Training Center
Amman / Jordan

ENTRY MEDICAL EXAMINATION

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 staff member liable to termination or dismissal.

Date:(dd/mm/yy) -- 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

POSITION APPLIED FOR (DESCRIBE NATURE OF WORK)	TELEPHONE	BIRTHPLACE

PRESENT MARITAL STATUS

Single ☐

Married ☐ DATE: (d/m/y) ------------------ **Divorced** ☐ DATE: (d/m/y) --------------

Separated ☐ DATE: (d/m/y) ------------------ **Widowed** ☐ DATE: (d/m/y) --------------

DUTY STATION

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: (d/m/y) 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 diseases		☐
Repeated bronchitis		☐	Gall stones		☐	Sleeplessness		☐	Amoebic dysentery		☐
Rheumatic fever		☐	Hernia		☐	Any nervous or mental disorder		☐	Malaria		☐
High blood pressure		☐	Haemorrhoids		☐	Frequent headaches		☐			☐

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 consultation:(d/m/y) __________
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 at least 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. **<u>FOR WOMEN</u>** 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 ____ Please attach tracing

RESPIRATORY SYSTEM

Thorax: ____

Breasts

DIGESTIVE SYSTEM

Abdomen : ____

Liver : ____

Spleen: ____

Hernia: ____

Rectal examination: ____

NERVOUS SYSTEM

Papillary 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 : ____ Upper extremities: ____

Spine: ____ Lower extremities: ____

LYMPHATIC SYSTEM

CHEST X-RAY (Please send only the radiologist's report based on a "full-size" X-ray film).

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:

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 post)

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: (d/m/y) ______