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: ____________________________________

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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: ____________________________________

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

If you have answered YES, please specify: ____________________________________

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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 ______________

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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: ______________

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

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

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Assessment of the Overall Health Condition

The client is healthy ☐

The client is undergoing treatment ☐ (please specify) ______________

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

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

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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: ______________________________________

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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: ______________________________

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

If you have answered YES, please specify: ______________________________

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

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

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

If you have answered YES, please specify: ______________________________

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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: ______________________________

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6. What more serious disease have you suffered? __________________________

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

If you have answered YES, please specify: ______________________________

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

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

If you have answered YES, please specify: ______________________________

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

If you have answered YES, please specify: ______________________________

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

If you have answered NO, please specify: ______________________________________

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Date ____________________ Signature ___________________________