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CONFIDENTIAL

ENTRY MEDICAL EXAMINATION

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 employment.

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
DUTY STATION		

PRESENT MARITAL STATUS

Single ☐

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

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

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. **FOR WOMEN** Are your periods regular? ☐ Yes ☐ No | Do you take contraceptive pills? ☐ Yes ☐ No If so, for
    Are they painful? ☐ Yes ☐ No | how many years have you been doing so? _____ Have you ever
    Do you have to stay in bed when they come? ☐ Yes ☐ No | been treated for a gynaecological complaint? ☐ Yes ☐ No
    If so, for how long? _____ Date of your last period: _____ 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 :		Peripheral arteries	
Rhythm :		Blood pressure :		-carotid :	
Apex beat :		Varicose veins :		-posterior tibial :	
				-dorsalis pedes :	

Electrocardiogram _____ Please attach tracing

RESPIRATORY SYSTEM — Breasts

Thorax: _____

DIGESTIVE SYSTEM — Spleen: _____

Abdomen : _____ Hernia: _____

Liver : _____ Rectal examination: _____

NERVOUS SYSTEM — Plantar reflexes : _____

Papillary reflexes: { - To light: _____ - On accommodation: _____

Motor functions : _____

Sensory functions : _____

Patellar reflexes : _____ Muscular tonus : _____

Achilles reflexes: _____ 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) _____