APPLICANT MEDICAL REPORT

PATIENT DETAILS:

SURNAME									FULL NAMES													
DATE OF BIRTH									ID NUMBER													
GENDER		MALE		FEMALE					CONTACT NUMBER													

MEDICAL AID DETAILS:

MEDICAL AID		YES		NONE	MEDICAL AID NAME													
PLAN/PACKAGE					MEDICAL AID NUMBER													
MAIN MEMBER					ID NUMBER													

This Medical Report is to be completed by a non-relative qualified medical practitioner during a medical examination of the patient/applicant. A copy hereof has to be submitted to the Rooted Impact Year as part of his/her application, and the original report submitted upon arrival at Impact 2020.

PERSONAL MEDICAL HISTORY:

GENERAL

Blood Type: ___________________

General health & fitness: ____

____

Allergies: ____

____

Comments ____

____

____

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MUSCULOSKELETAL

Physical impairments ___

Spinal ___

Neck ___

Back ___

Any other musculoskeletal problems, previous injuries, breaks? Specify: ___

___

CARDIOVASCULAR SYSTEM

Pulse Rate: ___ Character: ___ B.P.: ___

Is there any displacement of cardiac apex? ❑Yes ❑ No

If yes please specify ___

___

Cardiac sounds ___

Is there any evidence of cardiovascular disease? ___

Oedema? ___

Varicose veins? ___

Varicocele? ___

RESPIRATORY SYSTEM

Any tendency toward: ❑ Asthma ❑ Frequent cough ❑ Chest infections

Shape of chest ___

Percussion ___

Breath sounds ___

Comments ___

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DIGESTIVE SYSTEM

Tonsils ______________________________

Digestion ______________________________

General apetite ______________________________

Abdominal pains ______________________________

Function of bowels ______________________________

Is there any evidence of hernia? ❑ Yes ❑ No

Is there any evidence of hemorrhoids? ❑ Yes ❑ No

General abdominal examination ______________________________

____

FEMALE

Menstrual history ______________________________

Any dysmenorrhea ______________________________

Periods regular ❑ Yes ❑ No

Any unusual pain ❑ Yes ❑ No

Discharges ❑ Yes ❑ No

Pregnancy test results ❑ Positive ❑ Negative

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NERVOUS SYSTEM

Eyes and eyesight ______________________________

Prescription for glasses/contacts ______________________________

Ears and hearing ______________________________

Reflexes ______________________________

Insomnia ______________________________

Any history of epilepsy ______________________________

PSYCHIATRIC ILLNESS

Please comment on all past or present illnesses of which you are aware of:

❑ General mental health ______________________________

____

❑ Insomnia ______________________________

____

❑ Depression ______________________________

____

❑ Anxiety ______________________________

____

❑ Other ______________________________

____

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CHRONIC FATIGUE OR IMMUNE DEFICIENCY SYNDROME

Is there any history of CFIDS or ME? If so, please state dates, length and severity of illness

____

____

CURRENT PRESCRIPTION MEDICATION AND DOSAGE:

Medication: ______________________________Dosage: ____________________________

Medication: ______________________________Dosage: ____________________________

Medication: ______________________________Dosage: ____________________________

Medication: ______________________________Dosage: ____________________________

Medication: ______________________________Dosage: ____________________________

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DRUG SCREENING RESULTS:

If any of the following substances results to be positive from the urine sample, a full blood drug screen test will be required.

COC ❑ Positive ❑ Negative

mAMP ❑ Positive ❑ Negative

MDMA ❑ Positive ❑ Negative

OPI ❑ Positive ❑ Negative

THC ❑ Positive ❑ Negative

FAMILY HISTORY

Is there any history of psychiatric illness in the patient or any of the family members of this applicant? *Please include any known details of parents, siblings, grandparents, aunts, uncles and 1st cousins who are blood relatives.* ____________________

____

____

Is there any family history of early onset of diabetes mellitus, cardiovascular disease, thyroid disorder or other serious medical conditions? ____________________

____

____

GENERAL NOTES

Please comment on:

Is there anything we need to know not covered above? ____________________

____

Are there any further investigations we need to pursue? ____________________

____

Do you have any further comments? ____________________

____

____

____

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I certify that to the best of my knowledge all the information contained in this document is true and accurate.

Medical Practitioner ____

Practice Number: ____

Address:

Street Address:

____

____

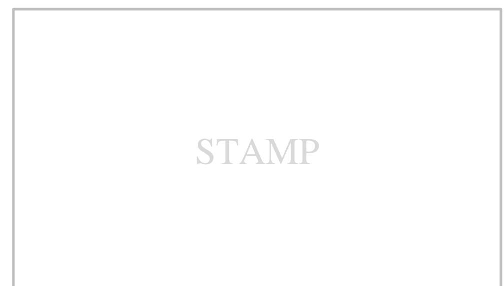
City: ___________________ Postal Code: ____________

Contact Details:

Tel.: ____

Email Address: ____

Signed: __________________________________



Date: ____________________________________

Note:
Please note that the applicant is responsible for the payment of this medical examination and report.