For Use in Canada Only

MEDICAL HISTORY AND PHYSICAL EXAMINATION
MEDICAL WORKSHEET THREE

For use with Main Medical Form

Name *(Last, First, MI)*		Exam Date *(mm-dd-yyyy)*
Birth Date *(mm-dd-yyyy)*	Passport Number	Alien *(Case)* Number

1. Past Medical History *(indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)*

NOTE: The following history has been reported, has not been verified by a physician, and should not be deemed medically definitive.

No Yes

General

☐ ☐ Illness or injury requiring hospitalization *(including psychiatric)*

Cardiology

☐ ☐ Angina pectoris

☐ ☐ Hypertension *(high blood pressure)*

☐ ☐ Cardiac arrhythmia

☐ ☐ Congenital heart disease

Pulmonology

☐ ☐ History of tobacco use
Current use ☐ Yes ☐ No

☐ ☐ Asthma

☐ ☐ Chronic obstructive pulmonary disease *(emphysema)*

☐ ☐ History of tuberculosis *(TB)* disease
Treated ☐ Yes ☐ No
Current TB symptoms ☐ Yes ☐ No

Neurology and Psychiatry

☐ ☐ History of stroke, with current impairment

☐ ☐ Seizure disorder

☐ ☐ Major impairement in learning, intelligence, self care, memory, or communication

☐ ☐ Major mental disorder *(including major depression, bipolar disorder, schizophrenia, mental retardation)*

☐ ☐ Use of drugs other than those required for medical reasons

☐ ☐ Addiction or abuse of specific* substance *(drug)*
*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ ☐ Other substance-related disorders *(including alcohol addiciton or abuse)*

☐ ☐ Ever taken action to end your life

No Yes

☐ ☐ Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs

Obstetrics and Sexually Transmitted Diseases

☐ ☐ Pregnancy Fundal height _____ cm
Last menstrual period Date *(mm-dd-yyyy)* _____

☐ ☐ Sexually transmitted diseases, specify _____

Endocrinology and Hematology

☐ ☐ Diabetes mellitus

☐ ☐ Thyroid disease

☐ ☐ History of malaria

Other

☐ ☐ Malignancy, specify _____

☐ ☐ Chronic renal disease

☐ ☐ Chronic hepatitis or other chronic liver disease

☐ ☐ Hansen's Disease
☐ Tuberculoid ☐ Borderline ☐ Lepromatous
OR ☐ Paucibacillary ☐ Multibacillary
Treated ☐ Yes ☐ No

☐ ☐ Visible disabilities *(including loss of arms or legs)*, specify

☐ ☐ Other requiring treatment, specify

2. Physical Examination *(indicate findings and give details in Remarks)*

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify

Height _____ cm Weight _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____

BP ____ / ____ *(mmHg)* Heart rate _____ /min Respiratory rate ____ /min Corrected L 20/ _____ R 20/ _____

***N, normal; A, abnormal; ND, not done**

N*	A*	ND*		N*	A*	ND*	
☐	☐	☐	General appearance and nutritional status	☐	☐	☐	Inguinal region *(including adenopathy)*
☐	☐	☐	Hearing and ears	☐	☐	☐	Extremities *(including pulses, edema)*
☐	☐	☐	Eyes	☐	☐	☐	Musculoskeletal system *(including gait)*
☐	☐	☐	Nose, mouth, and throat *(include dental)*	☐	☐	☐	Skin *(including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)*
☐	☐	☐	Heart *(S1, S2, murmur, rub)*	☐	☐	☐	Lymph nodes
☐	☐	☐	Breast	☐	☐	☐	Nervous system *(including nerve enlargement)*
☐	☐	☐	Lungs	☐	☐	☐	Mental status *(including mood, intelligence, perception, thought processes, and behavior during examination)*
☐	☐	☐	Abdomen *(including liver, spleen)*				
☐	☐	☐	Genitalia *(including circumcision, infection(s))*				

3. Additional Testing Needed Prior to Approving Medical Clearance

No Yes

☐ ☐ Physical examination or laboratory results contradict medical history

☐ ☐ Referral prior to departure If yes, provide results _____

☐ ☐ Referral prior to departure If yes, provide results _____

4. Follow-up Needed After Arrival

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months

☐ For continuing medication, list type, dose, and frequency _____

☐ For continuing other treatment, specify _____

5. Remarks *(describe any abnormal history, abnormal findings, and resulting interventions)*