

MEDICAL QUESTIONNAIRE

Please explain all "Yes" by number on the reverse side and list specific date, treatment (if any) and present status.

NAME			ADDRESS (Include Number, Street, City, State and Zip Code)				
AGE	SEX	HEIGHT	WEIGHT	COLOR OF EYES	COLOR OF HAIR	DATE OF BIRTH	
DISTINGUISHING MARKS AND SCARS							
PLEASE CHECK THE APPROPRIATE COLUMN IF YOU HAVE OR HAVE HAD THE FOLLOWING COMPLAINTS OR SYMPTOMS OR IF YOU HAVE BEEN ADVISED TO SEEK TREATMENT FOR:							
#	COMPLAINTS OR SYMPTOMS	YES	NO	#	COMPLAINTS OR SYMPTOMS	YES	NO
1.	Shortness of breath			43.	Painful or stiff joints		
2.	At rest			44.	Irritability		
3.	With exercise			45.	Frequent headaches		
4.	On lying down			46.	Dizziness or faintness		
5.	Heart attack			47.	Insomnia (Sleeplessness)		
6.	At rest – chest pain			48.	Nightmares		
7.	With exercise – chest pain			49.	Poor concentration		
8.	On lying down – chest pain			50.	Excessive fatigue		
9.	Swelling of ankles			51.	Tension – inability to relax		
10.	Cough			52.	Difficulty in coordinating		
11.	Spitting of blood			53.	Glaucoma		
12.	Night sweats			54.	Difficulty – seeing		
13.	Hot flashes			55.	Difficulty – hearing		
14.	Frequent respiratory infections			56.	Discharge from eyes		
15.	Wheezing in chest			57.	Discharge from ears		
16.	Loss of weight			58.	Discharge from nose		
17.	Gain in weight			59.	Discharge from nipples		
18.	Thyroid disease			60.	Ulceration of nipples		
19.	Gall bladder disease			61.	Lumps in breasts		
20.	Excessive belching			62.	Chronic hoarseness		
21.	Stomach ulcer			63.	Cataracts		
22.	Difficulty in swallowing			64.	Skin rash		
23.	Abdominal pain			65.	Hernia		
24.	Constipation			66.	Diabetes		
25.	Food intolerances			67.	Tumor or cancer		
26.	Frequent diarrhea			68.	Psychiatric treatment		
27.	Change in bowel habits			69.	Disability payments		
28.	Blood in stools			70.	Seizures (Convulsions)		
29.	Coal black stools			71.	Stroke		
30.	Vaginal discharge			72.	High blood pressure		
31.	Menstrual irregularities/pain			73.	Tuberculosis		
32.	Last (date) menstrual period			74.	Slipped Disc		
33.	Increased frequency of urination			75.	Multiple Sclerosis		
34.	Prostrate			76.	Polio		
35.	Blood in urine			77.	Advised to have surgery		
36.	Kidney stones			78.	Have you had Hepatitis B?		
37.	Painful urination			79.	Have you had Hepatitis C?		
38.	Muscular weakness – paralysis						
39.	Tingling in extremities						
40.	Pain in extremities						
41.	Backache						
42.	Swollen joints						
WHAT MEDICINES DO YOU TAKE EITHER REGULARLY OR OCCASIONALLY? VERY IMPORTANT							
AVERAGE DAILY CONSUMPTION TOBACCO _____ ALCOHOL _____		82. EVER BEEN REFUSED EMPLOYEMNT INSURANCE, OR MILITARY SERVICE FOR HEALTH REASONS? YES <input type="checkbox"/> NO <input type="checkbox"/>			ANY HOSPITALIZATION DURING LAST 10 YEARS FOR ANY REASON? <input type="checkbox"/> YES <input type="checkbox"/> NO SEE OTHER SIDE		
I hereby authorize a full report of my medical examination to be forwarded to King Faisal Specialist Hospital & Research Centre. I further affirm that the information and responses I have provided are accurate and true to the best of my knowledge.							
SGINATURE OF APPLICANT (Required)			DATE		POSITION APPLIED HIRED FOR		

* Questions which may be inconsistent with Civil Rights Legislation may be omitted.

MEDICAL CARE/HOSPITALIZATIONS IN PAST 10 YEARS

