DOCTOR Helena MEDICAL CLINIC

Date: _____ / _____ / _____
yyyy / mm / dd

IMMIGRATION MEDICAL INFORMATION

SECTION A: GENERAL INFORMATION

1. Last Name / Surname: _____

2. First & middle names: _____

3. Date of birth: (yyyyy / mm / dd) _____ /_____ /_____

4. Gender: Male ☐ Female ☐

5. Mailing address: _____

_____

6. Telephone: +____ (_____) _____ Cell: +____ (_____) _____

7. Country of birth: _____

8. Country of citizenship _____

9. ID document presented: Passport ☐ Driver License ☐ Refugee Doc ☐ Birth Certificate ☐

- ID document no.: _____
- ID document issuing country: _____
- ID document issue date: (yyyyy / mm / dd) _____ /_____ /_____
- ID document expiry date: (yyyyy / mm / dd) _____ /_____ /_____

10. IME / UMI number: _____

11. Category: Student ☐ Worker ☐ Visitor ☐ Family ☐ Refugee ☐

12. Date of arrival in Canada: (yyyyy / mm / dd) _____ /_____ /_____

13. Country of residency prior to arrival in Canada: _____

14. Occupation: _____

15. Home language: _____

16. Are you comfortable discussing your health history with the doctor in English? YES ☐ NO ☐

If NO, will you have an interpreter with you to help you? YES ☐ NO ☐

SECTION B: MEDICAL QUESTIONS

1. During the last 10 years:

Have you had any serious illness that required medical attention? NO ☐ YES ☐

Have you had major surgery? NO ☐ YES ☐

Have you had cancer of any kind? NO ☐ YES ☐

2. Do you take medications for a chronic medical condition? NO ☐ YES ☐

3. Have you ever been diagnosed with any of the following conditions / illness?

High blood pressure	NO ☐	YES ☐	Diabetes	NO ☐	YES ☐
Heart disease	NO ☐	YES ☐	High cholesterol	NO ☐	YES ☐
Blood disease	NO ☐	YES ☐	Lung disease	NO ☐	YES ☐
Kidney disease	NO ☐	YES ☐	Psychiatric illness	NO ☐	YES ☐
Dementia	NO ☐	YES ☐	Neurological illness	NO ☐	YES ☐
Stroke	NO ☐	YES ☐	Tuberculosis (TB)	NO ☐	YES ☐
Syphilis	NO ☐	YES ☐	HIV	NO ☐	YES ☐
Hepatitis B	NO ☐	YES ☐	Hepatitis C	NO ☐	YES ☐

4. Has anybody in your household ever been treated for Tuberculosis (TB)? NO ☐ YES ☐

5. Disabilities

All applicants: Do you have any special medical needs? NO ☐ YES ☐

Applicants older than 60: Do you live independently? NO ☐ YES ☐

Applicants between 18-60:
Do you have any medical condition preventing you from doing regular work? NO ☐ YES ☐

Applicants younger than 18 (Parent to answer)
Is the applicant able to attend a regular school? NO ☐ YES ☐

6. Do you have:

An addiction to alcohol or recreational drugs? NO ☐ YES ☐

Tattoos on your body? NO ☐ YES ☐

7. Women: Are you pregnant? NO ☐ YES ☐

If YES, what is your expected date of delivery? (yyyyy / mm / dd) / /

Signature of applicant (or Parent)

I declare that I have truthfully answered the above questions. _____

SECTION C: FOR USE OF THE DOCTOR ONLY

Height:	cm	%			
Weight:	kg	%			
Head circumference:	cm	%			
Blood pressure:	/ Mm Hg				
Vision:	Left: 6/ C / UC				
	Right: 6/ C UC				
Urine dip:	Protein: Neg /	1+	2+	3+	
	Glucose: Neg /	1+	2+	3+	
	Blood: Neg /	1+	2+	3+	