Annex B to SNMAS 08.03 Duty Fitness Medical Examination

Duty Fitness Medical Examination Record (Date: / /20--)

Dates Revised:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:				**F/Name**:			
Age:		Sex:	F ☒ M ☒	Date of last physical exam:			
Marital status:	☐ Single	☐ Partnered	☒ Married	☐ Separated	☐ Divorced	☐ Widowed	

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio	☐ Others Specify

Immunizations and dates:	☒ **Tetanus**	☒ **Pneumonia**
	☒ **Hepatitis**	☒ **Chickenpox**
	☒ **Influenza**	☐ **MMR**

List any medical problems that other doctors have diagnosed

Surgeries:

Year:	**Reason:**	**Hospital**

Other hospitalizations

Year:	**Reason:**	**Hospital:**

Have you ever had a blood transfusion?	☐ **Yes**	☒ **No**

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Do you have any allergies to medications?	
Name of the Drug?	**Reaction You Had?**

REVIEW OF SYSTEMS:

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

General Appearance	Weight Loss	☒	Yes	☐	No	Weight Gain	☒	Yes	☐	No	Fatigue	☒	Yes	☐	No
	Fever	☒	Yes	☐	No	Night Sweet	☐	Yes	☒	No					
Skin	Rashes	☒	Yes	☐	No	Pruritus	☒	Yes	☒	No	Impetigo	☐	Yes	☐	No
Head	Trauma	☒	Yes	☐	No	Dizziness	☒	Yes	☒	No	Syncope	☒	Yes	☐	No
Eye	Vision	☒	Yes	☐	No	Excessive Tearing	☒	Yes	☐	No	Cataract	☒	Yes	☒	No
Ear	Hearing Changes	☐	Yes	☒	No	Tinnitus	☒	Yes	☒	No	Pain(h)	☒	Yes	☒	No
	Discharge	☒	Yes	☒	No	Vertigo	☒	Yes	☐	No					
Nose	Sinus Problem	☐	Yes	☒	No	Epistaxis	☒	Yes	☐	No	Polyps	☒	Yes	☒	No
	Sense of Smell	☒	Yes	☒	No										
Throat	Bleeding Gum	☒	Yes	☐	No	Lesion On Tonsils	☒	Yes	☐	No	Mucosa Lesion	☒	Yes	☐	No
Respiratory System	Chest Pain ®	☒	Yes	☒	No	Dyspnoea	☒	Yes	☒	No	Dry Cough	☐	Yes	☒	No
	Hemoptysis	☒	Yes	☒	No	Sneezing	☒	Yes	☐	No	Productive cough	☐	Yes	☐	No
CVS	Chest Pain	☒	Yes	☒	No	Orthopnea	☒	Yes	☐	No	Exertional Dyspnoea	☒	Yes	☐	No
	PND	☐	Yes	☐	No	Claudication	☒	Yes	☐	No	Peripheral Oedema	☒	Yes	☒	No
GIS	Dysphagia	☒	Yes	☒	No	Nausea	☒	Yes	☒	No	Vomiting	☒	Yes	☒	No
	Diarrhoea	☐	Yes	☐	No	Constipation	☒	Yes	☐	No	Melina	☒	Yes	☐	No
	Jaundice	☐	Yes	☒	No	Food	☒	Yes	☒	No	Hematemises	☐	Yes	☒	No

						Intolerance									
Genitourinary System	Frequency	☒	Yes	☐	No	Urgency	☒	Yes	☒	No	Dysuria	☒	Yes	☒	No
	Heamaturea	☒	Yes	☐	No	Poly urea	☒	Yes	☒	No	Discharge	☒	Yes	☒	No
	Impotence	☒	Yes	☒	No										
Endocrine System	Poly depsia	☒	Yes	☐	No	Polyphagia	☒	Yes	☐	No	Temperature Intolerance	☒	Yes	☒	No
	Changes In Hair Or Skin Texture	☒	Yes	☒	No										
Musculoskeletal	Arthralgia	☒	Yes	☐	No	Trauma	☒	Yes	☐	No	Joint Swelling	☐	Yes	☐	No
	Limitation In Range or Motion	☒	Yes	☐	No	Back pain	☐	Yes	☒	No					
Peripheral Vascular	Varicose Veins	☒	Yes	☐	No	Intermittent Claudication	☒	Yes	☒	No	Thrombophlebitis History	☒	Yes	☒	No
Hematology	Anemia	☐	Yes	☐	No	Bleeding Tendency	☒	Yes	☐	No	Easy Bruising	☒	Yes	☐	No
Nervous	Syncope	☒	Yes	☐	No	Seizures	☒	Yes	☐	No	M Weakness	☒	Yes	☒	No
	M coordination	☒	Yes	☒	No	Memory	☒	Yes	☐	No	Sleep Pattern	☒	Yes	☐	No
	Emotional Disturbances	☐	Yes	☐	No										
Psychiatric															

PHYSICAL EXAMINATIONS									
All questions contained in this questionnaire are optional and will be kept strictly confidential.									
General Appearance	Mood		Unusual Position						
Vital Signs	Bp		PR		T				
Skin									

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Node	Location					Size						Tenderness				
	Motility															
Head																
Eyes	Conjunctiva					Enophthalmos						Pupil Size				
	Reactivity					Visual Activity	R E					LE				
Ears	Test Hearing					Discharge(E)	☐	Yes	☒	No		Tympani Membrane				
Neck	Nodes	☒	Yes	☐	No	Masses	☒	Yes	☒	No		Thyroid				
	Bruit	☒	Yes	☐	No											
R S	Inspection					Palpation						Precaution				
C V S	Inspection©					Palpation						Auscultation©				
G I S	Inspection					Palpation						precaution				
	Auscultation															
U G S	Inspection					Palpation						Precaution				

Medical Examiner:
Date of Examination:
Address:
Signature:

Senior Medical Officers Comments:

Signature: _____ Date: _____