MEDICAL FORM

All boxes MUST be completed in full, if no conditions are present please state "no abnormalities present"
Refer to Page 2 for more details about requirements of this exam.

Last Name:	Date of Birth:	Passport:			Hospital:
First Name:	Age:	Job Title:			Medical Insurance:
Middle Name:	Sex:	Marital status:			Physician:
Blood Group:	Weight:	Height:			Sitting Height:
Company Name:	Company Address & Phone:				
PAST MEDICAL HISTORY	Any Hospital stays / surgery:				
	Current Vaccination / immunization status:				
	Habits:		Allergies: (incl drugs)		
	Medical waivers: (specify date (s)				
PHYSICAL EXAMINATION	Physician Name: Surgeon Name:				
	OPHTHAMOLOGY.	LC NEA R IOP	OD OD OD	OS OS OS	CORR.
NEUROLOGICAL ISSUES:					
OTORHINOL ISSUES:					
PSYCHOLOGY ISSUES:					
OTHER ISSUES (specify):					
EKG REPORT FINDINGS:					
Medical Board Certification # Medical practice Address/Phone	DATE OF EXAM:	CONCLUSIONS/ FINDINGS/ RECOMMENDATIONS:			
	DOCTOR NAME:	DOCTOR TITLE:		DOCTOR SIGNATURES:	