



MEDICAL EXAMINATION REPORT (page 1 of 2)

(Please print)

Examination by licensed medical doctor. All information contained herein is confidential and for use by International Farmers Aid Association at their discretion and for the purpose of expediting medical care.

Name: (Last) (First) (Middle) (Maiden)

Birthdate: / / Sex: M F

Permanent Address: Number and Street City State Zip Code Phone

Person Cooperating Organization should notify in case of emergency: Name Relationship

Address Home Phone Work Phone

Family Physician: Name Phone

PERSONAL HISTORY

Have you had or do you have any of the following? (If yes, indicate dates).

- Yes No Yes No Yes No
Anemia (Including Sickle Cell)
Asthma
Diabetes
Cancer, tumors, cysis
High blood pressure
Heart disease
Chest or breathing problems
Blood disease
Convulsions,blackouts,epilepsy
Thrombophlebitis
Head injury w/ unconsciousness
Ear, Nose, Throat problems
Vision or hearing problems
Kidney or bladder problems
Liver disease
Severe headaches
Back or joint problems
Dizziness
Menstrual difficulties
Miscarriages or abortions
Thyroid problems
Skin rashes
Emotional problems; psychiatric disorder
Stomach or intestinal disorders; ulcer
Venereal disease
Syphillis, Herpes, Gonorrhea, AIDS
Infectious Mononucleosis
Rheumatic Fever
Tuberculosis
Other:

If answer to any of above is yes, explain. Include onset date, diagnosis, medication, and any limitations and residuals (use and attach extra sheet of paper, if necessary):

List any major operations, major illnesses, injuries, prolonged treatment, or hospitalization and dates:

Do you take any medicines on a regular basis? (including Birth Control Pills)

Yes No Specify:

Have you ever had a Tuberculin Skin Test? Yes No Date: Result:
If positive, what was done?

Did you ever have BCG Vaccine? Yes No

When was your last Tetanus/Diphtheria Shot?

Have you had or been vaccinated against German Measles? Yes No

FAMILY HISTORY

Has any member of your family (including grandparents) had any of the following? (Check only those that apply and state who).

- Asthma
Diabetes
Heart Disease
High Blood Pressure
Bleeding problems
Mental or emotional problems
Cancer
Epilepsy
Tuberculosis
Allergies
Other:

In case of illness and/or injury, permission is granted to treat the above named individual and to make the necessary referrals to outside physicians and faciilties, if indicated.

Applicant's Signature Date

Parent's Signature, if applicant is a minor. Date

**EXAMINATION BY LICENSED MEDICAL DOCTOR** (page 2 of 2)

**GENERAL APPEARANCE AND DEVELOPMENT:** Good  Fair  Poor  Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**VISION** For Distance – Without corrective lenses: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Both 20/ \_\_\_\_\_  
For Distance – With corrective lenses: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Both 20/ \_\_\_\_\_  
Evidence of Disease or Injury: \_\_\_\_\_ Right \_\_\_\_\_ Left \_\_\_\_\_  
Color Test (Red, Green, Amber Signal Recognition): \_\_\_\_\_  
Horizontal field of vision (must be in degrees): Right \_\_\_\_\_ Left \_\_\_\_\_

**HEARING** Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_  
Disease or injury: \_\_\_\_\_

**AUDIOMETRIC TEST:** (If audiometer is used to test hearing, must be in numerals)  
Decibel loss at 500 HZ \_\_\_\_\_ at 1,000 HZ \_\_\_\_\_ at 2,000 HZ \_\_\_\_\_

**THROAT** Condition: \_\_\_\_\_

**THORAX** Heart \_\_\_\_\_  
If organic disease is present, is it fully compensated? \_\_\_\_\_  
Blood pressure: Systolic \_\_\_\_\_ Diastolic \_\_\_\_\_ (reading over 160/90 requires explanation)  
Pulse: Before exercise \_\_\_\_\_ Immediately after exercise \_\_\_\_\_  
Lungs: \_\_\_\_\_

**ABDOMEN** Scars \_\_\_\_\_ Abnormal masses \_\_\_\_\_ Tenderness \_\_\_\_\_  
Hernia: No \_\_\_\_\_ Yes \_\_\_\_\_ If so, where? \_\_\_\_\_ Is truss worn? \_\_\_\_\_

**GASTROINTESTINAL** Ulceration or other disease: Yes \_\_\_\_\_ No \_\_\_\_\_

**GENITO-URINARY** Scars \_\_\_\_\_ Urethral Discharge \_\_\_\_\_

**REFLEXES** Romberg \_\_\_\_\_ Pupillary, Light \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_  
Accommodation: Right \_\_\_\_\_ Left \_\_\_\_\_  
Knee Jerks: Right: Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_  
Left: Normal \_\_\_\_\_ Increased \_\_\_\_\_ Absent \_\_\_\_\_  
Remarks: \_\_\_\_\_

**EXTREMITIES** Upper \_\_\_\_\_ Lower \_\_\_\_\_ Spine \_\_\_\_\_

**LABORATORY AND OTHER SPECIAL FINDINGS** Urine: Spec. Gr. (Must be in numerals) \_\_\_\_\_ Alb. \_\_\_\_\_ Sugar \_\_\_\_\_  
Other Laboratory Data \_\_\_\_\_  
Radiological Data \_\_\_\_\_  
Electrocardiograph \_\_\_\_\_

**ALLERGIES** Medicine or Drugs Food/Pollens  
 Penicillin  Aspirin  Eggs  
 Sulfa  Codeine  Other (Specify): \_\_\_\_\_  
 Horse Serum  Other (Specify) \_\_\_\_\_

**EXAMINING DOCTOR'S CERTIFICATION**

*I certify that I have examined:*

Date of Exam : \_\_\_\_\_

NAME (Print) \_\_\_\_\_

*I find this person qualified and fit to perform strenuous activities and those responsibilities as described in the "IFAA-Trainee Agreement".*

Name and Title of Examining Doctor (Print) \_\_\_\_\_

Medical License Number \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Signature of Examining Doctor \_\_\_\_\_

Phone Number \_\_\_\_\_

**PHYSICIAN'S GENERAL COMMENTS:** \_\_\_\_\_