

Patient’s Name: (Last, First, MI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Name and address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICAL EXAMINATION FOR THE ORDINATION PROCESS (ADGL)**

***To be filled out by applicant.*** *(Check the appropriate list below for the disorders you have or have had in the past.)*

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| **Infectious Diseases**  Pneumonia \_\_\_\_\_ Yes    \_\_\_\_\_  No  Frequent sore throats \_\_\_\_\_ Yes    \_\_\_\_\_  No  Dysentery (Chronic) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Infantile Paralysis (Polio) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Syphilis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Gonorrhea \_\_\_\_\_ Yes    \_\_\_\_\_  No  Skin diseases or eczema \_\_\_\_\_ Yes    \_\_\_\_\_  No  Fevers \_\_\_\_\_ Yes    \_\_\_\_\_  No  Recurrent chills \_\_\_\_\_ Yes    \_\_\_\_\_  No  Lymph node enlargement \_\_\_\_\_ Yes    \_\_\_\_\_  No  **Heart and Blood Vessels**  High or low blood pressure \_\_\_\_\_ Yes    \_\_\_\_\_  No  Heart disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Pain in chest \_\_\_\_\_ Yes    \_\_\_\_\_  No  Rheumatic Fever \_\_\_\_\_ Yes    \_\_\_\_\_  No  Heart murmur \_\_\_\_\_ Yes    \_\_\_\_\_  No  Palpitations \_\_\_\_\_ Yes    \_\_\_\_\_  No  Shortness of breath \_\_\_\_\_ Yes    \_\_\_\_\_  No  Swollen ankles \_\_\_\_\_ Yes    \_\_\_\_\_  No  Anemia or blood disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Coagulation disorder \_\_\_\_\_ Yes    \_\_\_\_\_  No  Elevated cholesterol \_\_\_\_\_ Yes    \_\_\_\_\_  No  **Digestive System**  Ulcers \_\_\_\_\_ Yes    \_\_\_\_\_  No  Jaundice \_\_\_\_\_ Yes    \_\_\_\_\_  No  Hepatitis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Recurrent diarrhea \_\_\_\_\_ Yes    \_\_\_\_\_  No  Bloody stools \_\_\_\_\_ Yes   \_\_\_\_\_  No  Marked over- or underweight \_\_\_\_\_ Yes    \_\_\_\_\_  No  Recent weight loss \_\_\_\_\_ Yes    \_\_\_\_\_  No  Gall bladder disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Hernia (rupture) \_\_\_\_\_ Yes    \_\_\_\_\_  No  **Miscellaneous**  Cancer \_\_\_\_\_ Yes    \_\_\_\_\_  No  Lymphoma/other blood disease      \_\_\_\_\_ Yes    \_\_\_\_\_  No  Diabetes or sugar disease (family) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Diabetes or sugar disease (self) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Thyroid disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Foot problems \_\_\_\_\_ Yes    \_\_\_\_\_  No  Back pain \_\_\_\_\_ Yes    \_\_\_\_\_  No  Joint pain \_\_\_\_\_ Yes    \_\_\_\_\_  No  Allergy to any food \_\_\_\_\_ Yes    \_\_\_\_\_  No  Allergy to medicines or injections \_\_\_\_\_ Yes    \_\_\_\_\_  No  Blood transfusions \_\_\_\_\_ Yes    \_\_\_\_\_  No  Arthritis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Use of nicotine on a daily basis  for past five years \_\_\_\_\_ Yes    \_\_\_\_\_  No  Habitual user of any habit-forming drugs or received treatments for  alcoholism or drug abuse \_\_\_\_\_ Yes    \_\_\_\_\_  No  Have you had any illness (mental or physical), or accidents  other than those mentioned? \_\_\_\_\_ Yes    \_\_\_\_\_  No  (If yes, please explain on back of page) | **Genitourinary System**  Kidney disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Kidney stones \_\_\_\_\_ Yes    \_\_\_\_\_  No  Prostate disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Bladder disease \_\_\_\_\_ Yes    \_\_\_\_\_  No  Blood in urine    \_\_\_\_\_ Yes    \_\_\_\_\_  No  Pain in passing urine \_\_\_\_\_ Yes    \_\_\_\_\_  No  Urinary tract infection \_\_\_\_\_ Yes   \_\_\_\_\_  No  **Respiratory System**  Sinus infection \_\_\_\_\_ Yes    \_\_\_\_\_  No  Asthma \_\_\_\_\_ Yes    \_\_\_\_\_  No  Hay Fever \_\_\_\_\_ Yes    \_\_\_\_\_  No  Bronchitis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Pleurisy \_\_\_\_\_ Yes    \_\_\_\_\_  No  Tuberculosis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Chronic cough \_\_\_\_\_ Yes    \_\_\_\_\_  No  Chronic hoarseness \_\_\_\_\_ Yes    \_\_\_\_\_  No  Coughing up blood \_\_\_\_\_ Yes    \_\_\_\_\_  No  Tobacco use \_\_\_\_\_ Yes    \_\_\_\_\_  No  **Nervous System**  Epileptic or other fits \_\_\_\_\_ Yes    \_\_\_\_\_  No  Migraine \_\_\_\_\_ Yes    \_\_\_\_\_  No  Meningitis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Mental or nervous disease (family) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Mental or nervous disease (self) \_\_\_\_\_ Yes    \_\_\_\_\_  No  Dizzy spells \_\_\_\_\_ Yes    \_\_\_\_\_  No  Fainting spells \_\_\_\_\_ Yes    \_\_\_\_\_  No  Visual problems \_\_\_\_\_ Yes    \_\_\_\_\_  No  Deafness \_\_\_\_\_ Yes    \_\_\_\_\_  No  Ringing ears/hearing difficulty \_\_\_\_\_ Yes    \_\_\_\_\_  No  Paralysis \_\_\_\_\_ Yes    \_\_\_\_\_  No  Weakness of limbs \_\_\_\_\_ Yes    \_\_\_\_\_  No  Numbness \_\_\_\_\_ Yes    \_\_\_\_\_  No |

I hereby declare that my answers to the above questions are full and true.

Signed at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in my presence this \_\_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2\_\_\_\_\_\_\_\_

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*Signature of PHYSICIAN*

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*Signature of APPLICANT*