

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    \_\_\_\_\_  NoFrequent sore throats \_\_\_\_\_ Yes    \_\_\_\_\_  NoDysentery (Chronic) \_\_\_\_\_ Yes    \_\_\_\_\_  NoInfantile Paralysis (Polio) \_\_\_\_\_ Yes    \_\_\_\_\_  NoSyphilis \_\_\_\_\_ Yes    \_\_\_\_\_  NoGonorrhea \_\_\_\_\_ Yes    \_\_\_\_\_  NoSkin diseases or eczema \_\_\_\_\_ Yes    \_\_\_\_\_  NoFevers \_\_\_\_\_ Yes    \_\_\_\_\_  NoRecurrent chills \_\_\_\_\_ Yes    \_\_\_\_\_  NoLymph node enlargement \_\_\_\_\_ Yes    \_\_\_\_\_  No**Heart and Blood Vessels**High or low blood pressure \_\_\_\_\_ Yes    \_\_\_\_\_  NoHeart disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoPain in chest \_\_\_\_\_ Yes    \_\_\_\_\_  NoRheumatic Fever \_\_\_\_\_ Yes    \_\_\_\_\_  NoHeart murmur \_\_\_\_\_ Yes    \_\_\_\_\_  NoPalpitations \_\_\_\_\_ Yes    \_\_\_\_\_  NoShortness of breath \_\_\_\_\_ Yes    \_\_\_\_\_  NoSwollen ankles \_\_\_\_\_ Yes    \_\_\_\_\_  NoAnemia or blood disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoCoagulation disorder \_\_\_\_\_ Yes    \_\_\_\_\_  NoElevated cholesterol \_\_\_\_\_ Yes    \_\_\_\_\_  No**Digestive System**Ulcers \_\_\_\_\_ Yes    \_\_\_\_\_  NoJaundice \_\_\_\_\_ Yes    \_\_\_\_\_  NoHepatitis \_\_\_\_\_ Yes    \_\_\_\_\_  NoRecurrent diarrhea \_\_\_\_\_ Yes    \_\_\_\_\_  NoBloody stools \_\_\_\_\_ Yes   \_\_\_\_\_  NoMarked over- or underweight \_\_\_\_\_ Yes    \_\_\_\_\_  NoRecent weight loss \_\_\_\_\_ Yes    \_\_\_\_\_  NoGall bladder disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoHernia (rupture) \_\_\_\_\_ Yes    \_\_\_\_\_  No**Miscellaneous**Cancer \_\_\_\_\_ Yes    \_\_\_\_\_  NoLymphoma/other blood disease      \_\_\_\_\_ Yes    \_\_\_\_\_  NoDiabetes or sugar disease (family) \_\_\_\_\_ Yes    \_\_\_\_\_  NoDiabetes or sugar disease (self) \_\_\_\_\_ Yes    \_\_\_\_\_  NoThyroid disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoFoot problems \_\_\_\_\_ Yes    \_\_\_\_\_  NoBack pain \_\_\_\_\_ Yes    \_\_\_\_\_  NoJoint pain \_\_\_\_\_ Yes    \_\_\_\_\_  NoAllergy to any food \_\_\_\_\_ Yes    \_\_\_\_\_  NoAllergy to medicines or injections \_\_\_\_\_ Yes    \_\_\_\_\_  NoBlood transfusions \_\_\_\_\_ Yes    \_\_\_\_\_  NoArthritis \_\_\_\_\_ Yes    \_\_\_\_\_  NoUse of nicotine on a daily basisfor past five years \_\_\_\_\_ Yes    \_\_\_\_\_  NoHabitual user of any habit-forming drugs or received treatments foralcoholism or drug abuse \_\_\_\_\_ Yes    \_\_\_\_\_  NoHave you had any illness (mental or physical), or accidentsother than those mentioned? \_\_\_\_\_ Yes    \_\_\_\_\_  No(If yes, please explain on back of page) | **Genitourinary System**Kidney disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoKidney stones \_\_\_\_\_ Yes    \_\_\_\_\_  NoProstate disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoBladder disease \_\_\_\_\_ Yes    \_\_\_\_\_  NoBlood in urine    \_\_\_\_\_ Yes    \_\_\_\_\_  NoPain in passing urine \_\_\_\_\_ Yes    \_\_\_\_\_  NoUrinary tract infection \_\_\_\_\_ Yes   \_\_\_\_\_  No**Respiratory System**Sinus infection \_\_\_\_\_ Yes    \_\_\_\_\_  NoAsthma \_\_\_\_\_ Yes    \_\_\_\_\_  NoHay Fever \_\_\_\_\_ Yes    \_\_\_\_\_  NoBronchitis \_\_\_\_\_ Yes    \_\_\_\_\_  NoPleurisy \_\_\_\_\_ Yes    \_\_\_\_\_  NoTuberculosis \_\_\_\_\_ Yes    \_\_\_\_\_  NoChronic cough \_\_\_\_\_ Yes    \_\_\_\_\_  NoChronic hoarseness \_\_\_\_\_ Yes    \_\_\_\_\_  NoCoughing up blood \_\_\_\_\_ Yes    \_\_\_\_\_  NoTobacco use \_\_\_\_\_ Yes    \_\_\_\_\_  No **Nervous System**Epileptic or other fits \_\_\_\_\_ Yes    \_\_\_\_\_  NoMigraine \_\_\_\_\_ Yes    \_\_\_\_\_  NoMeningitis \_\_\_\_\_ Yes    \_\_\_\_\_  NoMental or nervous disease (family) \_\_\_\_\_ Yes    \_\_\_\_\_  NoMental or nervous disease (self) \_\_\_\_\_ Yes    \_\_\_\_\_  NoDizzy spells \_\_\_\_\_ Yes    \_\_\_\_\_  NoFainting spells \_\_\_\_\_ Yes    \_\_\_\_\_  NoVisual problems \_\_\_\_\_ Yes    \_\_\_\_\_  NoDeafness \_\_\_\_\_ Yes    \_\_\_\_\_  NoRinging ears/hearing difficulty \_\_\_\_\_ Yes    \_\_\_\_\_  NoParalysis \_\_\_\_\_ Yes    \_\_\_\_\_  NoWeakness of limbs \_\_\_\_\_ Yes    \_\_\_\_\_  NoNumbness \_\_\_\_\_ 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*