MEDICAL REPORT
MEDICAL HISTORY QUESTIONS

UCI number:	IME number:	UMI number (if applicable)

Family name	Given name(s)	Date of birth (YYYY-MM-DD)

IF YOUR ANSWER IS YES TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE ADDITIONAL INFORMATION INCLUDING: DIAGNOSIS, DATE, AND TREATMENT (INCLUDING MEDICATIONS AND/OR MAJOR SURGERIES)

MEDICAL HISTORY QUESTIONS	RESPONSE	ADDITIONAL INFORMATION FOR "YES" RESPONSE ONLY
1. Tuberculosis (TB), treatment for tuberculosis	☐ No ☐ Yes	
2. Close household or work contact with Tuberculosis **(CXR will be required for all clients regardless of age)**	☐ No ☐ Yes	
3. Prolonged medical treatment and/or repeated hospital admissions for any reason, including a major operation or psychiatric illness	☐ No ☐ Yes	
4. Psychological/Psychiatric Disorder (including major depression, bipolar disorder or schizophrenia).	☐ No ☐ Yes	
5. An abnormal or reactive HIV blood test	☐ No ☐ Yes	
6. An abnormal hepatitis B or hepatitis C blood test	☐ No ☐ Yes	
7. Cancer or malignancy in the last 5 years	☐ No ☐ Yes	
8. Diabetes	☐ No ☐ Yes	
9. Heart condition including coronary disease, hypertension, valve or congenital disease	☐ No ☐ Yes	
10. Blood condition (including thalassemia)	☐ No ☐ Yes	
11. Kidney or bladder disease	☐ No ☐ Yes	
12. An ongoing physical or intellectual disability affecting your current or future ability to function independently or be able to work full-time (including autism or developmental delay).	☐ No ☐ Yes	
13. An addiction to drugs or alcohol	☐ No ☐ Yes	
14. Are you taking any prescribed pills or medication (excluding oral contraceptives, over-the-counter medication and natural supplements)	☐ No ☐ Yes	
15. **For female clients:** a) Are you pregnant?	☐ No ☐ Yes	
b) If yes, what is the expected date of delivery?	Date (YYYY-MM-DD)	
c) Do you wish to proceed with the required x-ray examination?	☐ No ☐ Yes	