MEDICAL REPORT
MEDICAL HISTORY QUESTIONS

IME #

UMI # (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	