Record of Medical History for Selection
(To be filled in by the applicant)

First name: __________________________ Last name: ______________________________

Date of Birth: ____________________

Address: ____ City: _______________________

Province: ____ Postal Code: ________________

NOTE: Applicants are Responsible for ensuring that they understand the questions below. Applicants are advised to consult with a family physician to gain clarity and/or to review the completed responses, if required. Untruthful or misleading information may result in employment disqualification or dismissal, if already hired.

HAVE YOU EVER BEEN DIAGNOSED WITH, OR UNDERGONE TREATMENT FOR, ANY ILLNESS, DISEASEES OR CONDITIONS ASSOCITAED WITH:

Please circle YES or NO for the appropriate answer:

1) Labyrinthitis, glaucoma or other condition of the eyes, ears, nose or throat?

   YES or NO

2) Refractive surgery of any type (including intra ocular lenses, phakic intraocular lens implants or implantable contact lenses), non-surgical reshaping of the eye (orthokeratology) or corneal transplant?

   YES or NO

3) Infection with or past exposure to tuberculosis, pleurisy, asthma, chronic bronchitis, pulmonary fibrosis, pulmonary embolus, pneumonia, previous intubation or any condition afflicting the respiratory system?

   YES or NO

4) Hypertension (elevated blood pressure), circulation disorder, deep vein thrombosis, infection involving the heart, heart murmur, heart valve irregularity, heart attack, angina, coronary disease, heart failure, irregular electrocardiogram, (ECG), or other condition afflicting the cardiovascular system?

   YES or NO

5) Peptic ulcer, gastrointestinal bleeding, inflammatory bowel disease, hernia, disease or inflammation of the oesophagus. Stomach, liver, gallbladder, pancreas, small intestine, colon or any other condition afflicting the gastrointestinal (digestive) system?

   YES or NO

6) Nephritis, documented blood, protein or glucose in your urine, disease or inflammation of the kidney, kidney stones, bladder, prostate or any other condition afflicting the urinary system?

   YES or NO

First name: _________________________ Last name: _____________________________

7) Epilepsy, seizures, multiple sclerosis, Tourette Syndrome, cerebral palsy, muscular dystrophy, Parkinson's disease, poliomyelitis, spina bifida, damage to a nerve or the nervous system, head injury, neurological deficit or any other condition afflicting the nervous system?

YES **or** **NO**

8) Diabetes, thyroid disorder or any other condition of the endocrine system?

YES **or** **NO**

9) Rheumatism, arthritis, gout, disc disease, chronic back pain, arthroplasty, trauma, or any other condition afflicting the back or other areas of the musculoskeletal system?

YES **or** **NO**

10) Disease or condition afflicting the skin?

YES **or** **NO**

11) Bleeding disorder, anemia, immune deficiency, blood product deficiency, abnormality, hypercoagulable state or any other condition of the blood system?

YES **or** **NO**

12) Infection with or past exposure to hepatitis virus (A, B or C)?

YES **or** **NO**

13) Infection with or past exposure to human immunodeficiency virus (HIV) or any other ongoing infection?

YES **or** **NO**

14) Cancer of any kind?

YES **or** **NO**

15) Depression, mania, schizophrenia, panic attacks, or any other conditions afflicting your mental health?

YES **or** **NO**

16) Attention Deficit Hyperactivity Disorder, obsessive/compulsive disorder or anger management problems?

YES **or** **NO**

17) Have you ever been diagnosed with a congenital abnormality?

YES **or** **NO**

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First name: __________________________ Last name: ______________________________

DO YOU CURRENTLY, OR HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

1) Shortness of breath, wheezing, chronic cough, cough producing blood or change in voice?

   YES or **NO**

2) Palpitations (awareness of an irregularity in your heart rate), dizziness, fainting or near fainting, swelling of the ankles, shortness of breath with minimal exercise or lying down flat, any sense of pain, pressure or tightness in the chest, neck or arms?

   YES or **NO**

3) Difficulty swallowing, sores or pain in the mouth, change in bowel habits, blood in your stools, jaundice, or a significant period of diarrhoea, nausea, vomiting or abdominal pain?

   YES or **NO**

4) Incontinence, difficulty urinating, pain or discharge from the genitals, change in colour of your urine?

   YES or **NO**

5) Tremor or shakiness, memory loss, headaches, decreased balance or coordination, decreased hearing, vision, taste or smell, decreased strength, decreased sensation or tingling in your hands or feet?

   YES or **NO**

6) Decreased range of motion in your neck or other major joints, joint pain, stiffness or swelling?

   YES or **NO**

7) Are or marks on the skin that has changed in colour or size, persistent sores, undiagnosed skin irregularities or bumps?

   YES or **NO**

8) Periods of feeling depressed, helpless, worthless or suicidal?

   YES or **NO**

9) Feelings of unprovoked anxiety, panic, accelerated heart rate or dizziness?

   YES or **NO**

10) Difficulty sleeping, fatigue, weight change of more than 15 pounds or 7 kilograms in the last six months?

    YES or **NO**

11) Repetitive, forceful and involuntary moments of the body?

    YES or **NO**

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First name: _________________________ Last name: _____________________________

HAVE YOU EVER:

1) Been physiologically or psychologically dependent on drugs or alcohol?
YES **or** **NO**

2) Had anyone express a concern about your alcohol consumption?
YES **or** **NO**

3) Felt badly, or guilty, about your drinking or felt you should drink less?
YES **or** **NO**

4) Had an alcoholic drink first thing in the morning to steady your nerves or get rid of a hangover?
YES **or** **NO**

PLEASE LIST ANY:

1) Medications you have taken in the last 12 months.

____

____

2) Allergies and associated reactions.

____

____

3) Operations you have had (i.e. laser eye surgery, coronary by-pass surgery, appendectomy, etc.) and the year that they were performed.

____

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PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) Do your parents, grandparents' siblings or children have a history of: Cancer, diabetes, coronary heart disease multiple sclerosis, hypertension or mental illness? If yes, indicate.

____

____

2) Do you smoke, or did you smoke previously? If yes please indicate frequency and duration.

____

____

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3) Do you have any other medical, psychological or physical disorder that was not identified above?
   ____
   ____

It is important that you consider carefully all answers to the questions above before signing the following declaration. Remember that untruthful or misleading responses may result in employment disqualifications or dismissal, if already hired.

I, THE UNDERSIGNED, DECLARE THAT THE ANSWERS TO THE ABOVE QUESTIONS ARE FULL, COMPLETE AND TRUE, AND ARE CORRECTLY RECORDED.

_____________________________________ _____________________________________
Signature of Applicant Signature of Witness to Applicant's Signature

____
Date