

**MEDICAL
SCREENING
QUESTIONNAIRE**

PERSONAL PARTICULARS

Full Name: _____

NRIC No: _____ Age: _____ years

Telephone No: (Home): _____ (Mobile): _____

Email Address: _____

- Under Section 5(b) of the Enlistment Act, you are required to disclose to us the state of your health and physical condition. This will help us to determine your fitness for service, and to take your medical condition into consideration during military training.
- On the day of your Medical Examination, please **WEAR/BRING YOUR SPECTACLES and DO NOT WEAR CONTACT LENSES.**

Please tick (✓) the appropriate boxes and provide details in the space provided. If there is insufficient space, please attach an additional sheet to this questionnaire printout.

Please consult your endorser when completing Section A to C of the questionnaire and ensure that your endorser acknowledges and completes Section D (Applicable to all pre-enlistees/applicants/volunteers under the age of 21).

A. DRUG ALLERGY & G6PD DEFICIENCY

		Yes	No	If yes, please specify the name of medication and type of reaction. If you are allergic to more than one type of medication, please provide us with the details.
1.	Any allergic reaction to medication?	<input type="checkbox"/>	<input type="checkbox"/>	

		Yes	No	If yes, please specify
2.	G6PD deficiency	<input type="checkbox"/>	<input type="checkbox"/>	

B. PERSONAL MEDICAL HISTORY

Do you have any of the following medical conditions? If yes, please tick (✓) and proceed to provide details in the columns following:

S/N	Medical Conditions	Currently on medication for the indicated medical condition?				Date of last hospitalisation (if any) for the indicated medical condition	If yes, please provide other relevant details
		Yes	No	Yes	No		
1.	Childhood illnesses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2.	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3.	Asthma/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.	Epilepsy/fits/faints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
5.	Digestive problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
6.	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
7.	Kidney problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8.	Skin problem/allergy/bad rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

MEDICAL-IN-CONFIDENCE

		Yes	No	Yes	No		
9.	Injury/fracture/bone /joint problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
10.	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
11.	Easy bruising or bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
12.	Eye condition/Previous Corneal Refractive Surgery/Intend to go for Corneal Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
13.	Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
14.	Mental illness/psychiatric condition/have consulted a psychiatrist at the Child Guidance Clinic, Institute of Mental Health or any other clinic/hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
15.	History of loss of consciousness during exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
16.	Others (<i>specify</i>):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

C. FAMILY HISTORY

For Section C, please consult your **parents and siblings** and indicate if anyone of them has the following medical conditions:

S/N	Medical Conditions	Yes	No	If yes, please specify family member(s) affected & the relevant details
1.	Heart disease/heart attack before 55 years in males and 65 years in females	<input type="checkbox"/>	<input type="checkbox"/>	
2.	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Death before the age of 40	<input type="checkbox"/>	<input type="checkbox"/>	
8.	Sudden death/sudden cardiac death	<input type="checkbox"/>	<input type="checkbox"/>	
9.	Genetic disease	<input type="checkbox"/>	<input type="checkbox"/>	
10.	Others	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICAL-IN-CONFIDENCE

D. ENDORSER'S DECLARATION (APPLICABLE TO ALL PRE-ENLISTEES/APPLICANTS/VOLUNTEERS UNDER THE AGE OF 21)

I certify that the above is correct to the best of my knowledge and my endorsee has consulted me when completing Sections A, B and C of this form. I understand that the Medical Classification Centre may access my endorsee's medical records, strictly for the purpose of medical screening and classification.

Name of endorser

Relationship to pre-enlistee/applicant/volunteer

Signature of endorser

Date

If your endorser is not your parent/next-of-kin or if you do not have an endorser, please state a reason:

E. SOCIAL HISTORY

S/N	Social History	Yes	No	If yes, please provide more details
1.	Do you have any medical/social/personal issues (e.g. homosexuality) that you wish to tell the Medical Officer in private?	<input type="checkbox"/>	<input type="checkbox"/>	
2.	Have you ever attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>	
3.	Do you have any tattoos?	<input type="checkbox"/>	<input type="checkbox"/>	
4.	Are you or your family suffering from financial difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	
5.	Do you have relationship issues with family/girlfriend/others?	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Do you have any history of drug abuse/glue sniffing	<input type="checkbox"/>	<input type="checkbox"/>	

F. SMOKING HISTORY

I am a: Smoker Ex-smoker Non-smoker

- Smoking _____ cigarettes per day
- Smoke for _____ months / years
- Stopped for _____ months / years

G. PERSONAL DECLARATION

I declare that I have read and understood this questionnaire. All of the above is complete and correct to the best of my knowledge. I understand that the Medical Classification Centre may access my medical records, strictly for the purpose of medical screening and classification.

Signature of pre-enlistee/applicant/volunteer

Date