Medical Declaration (confidential after being filled out)

Section A: Medical Questionnaire for Security Forces Applicants (to be filled out by the applicant)

Personal details:

I.D. No.	Last name	First name	Date of birth	Father's name	Gender	Planned date of enlistment

Please fill in the following information:

Home phone	Cell phone	email address	Date of birth	I am in the 10th/11th/12th grade (circle the correct grade)	Kupat Holim (name and address)

10^{th} graders need to fill in Part D only.

Do you suffer from any of the following symptoms?

Symptom		Do you suffer from this disorder? (*)		Have you ever been hospitalized for this disorder? (*)		Place and date of hospitalization
		yes	no	yes	no	
1.	Head injury or concussion					
2.	Recurrent headaches, fainting, dizziness, convulsions					
3.	Hearing impairments, recurrent ear infections					
4.	Allergic runny nose, sinusitis, difficulty breathing through the nose					
5.	Vision impairment, need for corrective lenses, color blindness, recurrent eye infections					
6.	Laser treatment for correcting nearsightedness					
7.	Blood pressure problems, loss of consciousness under exertion					
8.	Heart disease, chest pain, changes in pulse rate while resting/exerting					
9.	Asthma, wheezing, shortness of breath, other respiratory diseases					
10.	Endocrinological diseases (hormonal disorders)					
11.	Ulcers, heartburn, recurrent stomach aches, jaundice, hepatic diseases					
12.	Intestinal infections, gastrointestinal bleeding, hemorrhoids					
13.	Blood disorders (i.e. anemia, thrombocytopenia)					
14.	Recurrent back pain, back injury					
15.	Leg/foot pain, walking difficulties, ankle problems, tendency toward recurrent sprained ankle					
16.	Bone/joint diseases					
17.	Bones fractures, dislocated shoulder					
18.	Skin diseases, moles					
19.	Excessive sweating of hands or feet which interferes with normal function					
20.	Allergies, oversensitivity to insect bites, medications and other substances					
21.	Kidney disease, urinary problems, bed wetting					

22.	For males - problems with testicles, inguinal hernia, pain in the groin					
23.	For females - problems with menstrual cycle, gynecological disease					
24.	Tuberculosis, chronic cough or bloody cough					
25.	Oncological disease, currently or in the past					
26.	Have you ever undergone surgery?					
27.	Are you an AIDS patient/carrier?					

Symptom		yes (*)	no	If yes, provide details.
28.	Do you take any regular medications?			
29.	Are you allergic to any medications?			
30.	Have you consulted with or been treated by a psychologist?			
31.	Do you use drugs or alcohol?			

Familial diseases: Does anyone in your immediate family (parents, siblings) suffer from any of the following diseases? (If so, indicate their relationship to you.)

Symptom		Does	Does not	Relationship	Details
32.	Diabetes				
33.	High blood cholesterol				
34.	High blood pressure				
35.	Cardiovascular disease, died at an early age				
36.	Chronic respiratory disease, tuberculosis				
37.	Congenital diseases (inherited)				
38.	Cancer				
39.	Other (detail)				

Applicant's Declaration:

I certify that the information I have given is true and complete and that I have not omitted any medical information.
I understand that a false declaration may result in damage to my health.
I understand that a false declaration is an offense and will lead to my prosecution.

Date	I.D. Number	Last name	First name	Signature
_____	_____	_____	_____	_____

Section B: to be filled out by family physician

To the physician: Please note that giving incomplete or inaccurate medical information may lead to the applicant's improper placement in the I.D.F, and may endanger the applicant's health.

Symptom		Does the applicant suffer from this disorder? (*)		Has the applicant ever been hospitalized for this disorder? (*)		Place and date of hospitalization
		yes	no	yes	no	
40.	Neurological disease (including epilepsy)					
41.	Endocrinological disease					
42.	Hematological disease (including anemia)					
43.	Diseases of the eye, night blindness, laser treatment					

44.	Ear, nose and throat disease					
45.	Respiratory disease (including asthma)					
46.	Cardiovascular disease, heart defects, hypertension					
47.	Renal disease and urinary disorders					
48.	Gastrointestinal or hepatic disease					
49.	Rheumatoid disease, skeletal disorders (including bone fractures)					
50.	Dermatological disease					
51.	Oncological disease					
52.	Mental disorders					
53.	Psychological treatment					
54.	Drugs and alcohol					
55.	Congenital diseases					
56.	Tuberculosis					

Symptom		yes (*)	no	If yes, provide details.
57.	Does the applicant take any regular medications?			
58.	Is the applicant allergic to any medications?			
59.	Is the applicant allergic to any foods/insect bites?			
60.	Has the applicant undergone any special tests?			
61.	Is the applicant under any regular clinical supervision?			
62.	Has the applicant undergone surgery?			
63.	Is the applicant known to be an H.I.V. carrier/patient?			
64.	Blood pressure: _____	65	Pulse: _____	66 Weight (kg) _____ 67 Height (cm) _____

(*) Please mark with an X where appropriate.

Notes:
a. Please attach detailed medical letters, or copies of hospitalization release letters or regular clinical supervision summaries for any illnesses.
b. In cases of hypertension, please attach the last 10 B.P. readings taken by Kupat Holim over the past two months.
c. If the applicant has undergone biopsies and/or removal of moles, please attach any relevant histological reports.

Comments: _____

_____

Physician's Declaration:
I certify that to the best of my knowledge the information I have given is true and that I have not omitted any medical information.

_____	_____	_____	_____	_____	_____
Date	Kupat Holim-Branch	Phone - Kupat Holim	Name of Physician	License No.	Signature and Stamp