

**MEDICAL
SCREENING
QUESTIONNAIRE**

<u>PERSONAL PARTICULARS</u>	
Full Name:	_____
NRIC No:	_____ Age: _____ years
Telephone No: (Home):	_____ (Mobile): _____
Email Address:	_____

- Under the Enlistment Act, you are required to disclose to us the state of your health and physical condition. This is to help us determine your fitness for National Service and to consider your medical condition(s) during military training.
- You are required to complete all sections.
- Your parent, guardian or next-of-kin will need to endorse the following sections: Drug Allergy & G6PD Deficiency, Personal Medical History and Family History. Please ensure that the person you have indicated to endorse the form is above 21 years old and has full knowledge of your medical history.
- You will then be asked questions on your smoking history. This section will not require any endorsement from your parent or guardian.

Please tick (✓) the appropriate boxes and provide details in the space provided.

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(s) and type of reaction(s). 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"/>	
2.	G6PD deficiency	<input type="checkbox"/>	<input type="checkbox"/>	

B. PERSONAL MEDICAL HISTORY

Do you have any of the following medical conditions? If you have any of the medical conditions, please provide other relevant details. For medical data protection, kindly refrain from entering medical diagnoses in this form, this will be further explored and clarified at the Medical Officer consult.

S/ N	Medical Conditions	Are you currently on medication for the indicated medical condition?			
		Yes	No	Yes	No
1.	Childhood illness	<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.	Breathlessness/lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	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.	Liver problem	<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"/>

MEDICAL-IN-CONFIDENCE

S/N	Medical Conditions	Are you currently on medication for the indicated medical condition?			
		Yes	No	Yes	No
8.	Skin condition/allergy/bad rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	Attended formal counselling with a healthcare professional	<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	<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 any one 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 old for males and 65 years old for 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 health condition	<input type="checkbox"/>	<input type="checkbox"/>	
6.	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
7.	Death before 40 years old	<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"/>	

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 that he/she has consulted me when completing the above sections of this form.

I understand that the Medical Classification Centre may access his/her medical records, including information relating to this declaration, subsequent medical examinations and investigations, strictly for the purpose of medical screening and classification.

I acknowledge that he/she may be required to undergo further investigations based on this information and consent to such information being stored and used for operational purposes, including but not limited to the compilation and analysis of statistics.

Name of endorser

Relationship to pre-enlistee/applicant/volunteer

Signature of endorser

Date

INFORMATION IN THE FOLLOWING SECTIONS WILL NOT BE SHARED WITH YOUR ENDORSER

E. SMOKING HISTORY

I am a: Smoker Ex-smoker Non-smoker

If you are a smoker, please indicate the following:

- Number of cigarettes per day ____
- How long have you been smoking? ____ years ____ months

If you are an ex-smoker, please indicate the following:

- Number of cigarettes you used to smoke per day ____
- How long were you smoking for before you stopped? ____ years ____ months

F. 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, including information relating to this declaration, subsequent medical examinations and investigations, strictly for the purpose of medical screening and classification.

I acknowledge that I may be required to undergo further investigations based on this information and consent to such information being stored and used for operational purposes including but not limited to the compilation and analysis of statistics.

Signature of pre-enlistee/applicant/volunteer

Date

G. PERSONAL DECLARATION (*Applicable to pre-enlistees aged 21 years old and above*)

I declare that I am aged 21 years old and above and do not have an endorser who is familiar with my medical history.

Signature of pre-enlistee/applicant/volunteer

Date