



EUROPEAN COMMISSION
MEDICAL SERVICE

MEDICAL EXAMINATION BEFORE APPOINTMENT

I THE UNDERSIGNED,, UNDERTAKE TO SUPPLY ANY DOCUMENTARY MEDICAL EVIDENCE RELEVANT TO MY STATE OF HEALTH DEEMED NECESSARY FOR THE PURPOSE OF JUDGING MY FITNESS FOR EMPLOYMENT IN ANY OF THE EUROPEAN INSTITUTIONS (*).

I DECLARE THAT MY ANSWERS TO THE FOLLOWING QUESTIONS ARE, TO THE BEST OF MY KNOWLEDGE, TRUE, COMPLETE AND ACCURATE. I AM AWARE THAT ANY INACCURACY OR OMISSION FOR WHICH I AM RESPONSIBLE MAY RENDER THE FINDING OF MEDICAL FITNESS NULL AND VOID.

Date: Signature:

AN OFFICIAL'S OR OTHER SERVANT'S PERSONAL MEDICAL RECORD IS STORED IN THE MEDICAL SERVICE OF THE INSTITUTION AT WHICH HE OR SHE IS EMPLOYED

(in block capitals)
Surname Forenames
Sex Marital status
Address (street, town, county, country).....
Tel. (office) (home) E-mail (office)
E-mail (home).....
Date of birth Place of birth Nationality
Position applied for (nature of work, competition No, category)
Status: official, member of temporary staff, member of contract staff, other
Place of employment

Have you undergone a medical examination for a European institution at any time in the past?
Have you ever been employed by a European institution?
If so, when?
Position..... Status

- (*) The medical examination before appointment is intended to
• determine physical fitness for employment (**) in any of the European institutions in accordance with
◦ Articles 28(e) and 33 of the Staff Regulations
◦ Articles 12(2)(d) and 13, and 82(3)(d) and 83 of the Conditions of employment of other servants (CEOS)
• determine the entitlement to guaranteed benefits in respect of invalidity or death, as provided for in
◦ Annex VIII, Article 1, of the Staff Regulations
◦ Articles 28, second paragraph, 32, 95, and 100 of the CEOS
• protect the health of staff (not least under European directives)

(**) An institution's medical officer may base a finding of fitness or unfitness not just on any physical or mental disorders from which a person might be suffering at the time of the examination, but also on a medically justified prognosis of potential disorders capable of jeopardising the normal performance of the duties in question in the foreseeable future (Court of First Instance, Cases T-121/89 and 6T-13/90).

This 'pre-appointment examination document' conforms to Regulation (EC) No 45/2001 of the European Parliament and of the Council on the protection of individuals with regard to the processing of personal data.

FAMILY MEDICAL HISTORY

Has any member of your family (father, mother, brother(s), sister(s)) suffered from

- cardiovascular disease (high blood pressure, coronary problems, etc.)
- respiratory disorders (asthma, tuberculosis, etc.)
- cancer
- mental illness (manic depression, schizophrenia, Alzheimer's disease, depression, other)
- neurological disorders (epilepsy etc.)

PERSONAL MEDICAL HISTORY

ANSWER 'YES' OR 'NO' TO EACH QUESTION; IF THE ANSWER IS 'YES', GIVE THE DATE. LEAVING A BLANK OR DRAWING A LINE OR CROSS IS NOT A SUFFICIENT ANSWER. IF THE QUESTIONNAIRE IS NOT COMPLETED IN FULL, FURTHER ENQUIRIES WILL BE NEEDED; INVOLVING A DELAY.

1. Have you suffered from any of the following diseases or disorders? If so, please specify the year and give details:

	YES Date	NO		YES Date	NO
Frequent angina	Urinary tract disease	.....	.....
Hay fever	Genital organ disease	.....	.....
Asthma	Lumbago	.....	.....
Tuberculosis	Joint pain	.....	.....
Pneumonia	Skin disease	.....	.....
Pleurisy	Insomnia	.....	.....
Frequent bronchitis	Depression	.....	.....
Acute rheumatoid arthritis	Nervous or mental disorders	.....	.....
High blood pressure	Frequent headaches	.....	.....
Cardiovascular disease	Fainting	.....	.....
Pain in the heart region	Epilepsy	.....	.....
Varicose veins	Diabetes	.....	.....
Digestive disorders	Sexually transmitted diseases	.....	.....
Stomach ulcer	Tropical diseases	.....	.....
Duodenal ulcer	Amoebiasis	.....	.....
Jaundice, hepatitis	Malaria	.....	.....
Gallstones	Eye disorders	.....	.....
Hernia	Ear disorders	.....	.....
Haemorrhoids	Tumours, cancer	.....	.....

2. Give details of any medical condition for which you are currently being treated.....

3. Have you ever been treated in hospital or at a clinic .? Where, when and for what reason?

Have you ever undergone surgery? Specify nature of operation(s) and date(s)

4. Have you ever been absent from work for more than a month because of illness?.....
If so, when? What was the illness?
5. Do you have a partial permanent incapacity for work following an accident or illness?
If so, since when? Nature of the disability
6. Have you ever consulted a neurologist, psychiatrist, psychoanalyst or psychotherapist?
If so, give his/her name and address:
What was the reason for the consultation?Date
7. Have you ever undergone treatment for alcohol addiction?
for drug addiction?
8. Do you regularly take any medication (including oral contraceptives)?
Please give details.....
9. Have you gained or lost weight over the last three years? If so, how much?.....
10. Have you ever undergone radiological or nuclear medicine examinations? If so, which examinations?.....
.....
11. Have you ever undergone courses of radiotherapy or chemotherapy?
If so, specify the treatments
12. Have you ever been turned down for a job for health reasons?If so, what were the reasons?
13. Have you ever spent time in a tropical country? If so, how long?
14. Do you consider yourself
- to be in good health?
- to be fully fit to work?
15. Do you smoke regularly?
If so, do you smoke cigarettes a pipe cigars?
What is your consumption of the above?
For how many years have you been smoking?
16. Are you often tired for long periods and/or for no apparent reason?
17. What is your daily/weekly alcohol consumption?
Do you take or have you ever taken narcotic or other non-medical drugs?
18. Has your doctor or dentist told you that you will need medical or surgical treatment in the near future?.....
19. Any other important information about your health:.....
.....
20. Do you play any sport? Specify
21. What is your current occupation?
22. Have you suffered medical problems when working on screen?
23. Have you ever had an industrial accident or suffered from an occupational disease?
Have you suffered any after-effects?
Do you suffer from any resulting partial permanent invalidity?
24. List any occupational or other hazards to which you have been exposed
25. For women: the urine test has to allow for menstruation. Where applicable, please give the date of your last period
.....

DATE SIGNATURE.....

DOCTOR'S COMMENTS ON MEDICAL HISTORY:

MEDICAL EXAMINATION

General appearance: Weight Height
Skin Subcutaneous fat

Mental state:

Head and neck:
Tongue Teeth Ears - Nose - Throat
Thyroid gland Tonsils

Heart and circulation:
Action Blood pressure
Murmurs Pulse

Lungs
Percussion Auscultation

Abdomen:
Liver Abdominal wall
Intestines Spleen
Hernial openings

Skeletal structure and muscles:

Urogenital tract:

Common integument and ganglions:

Central nervous system:
Form of pupils Pupillary reflex Cranial nerves Babinski
Patellar reflex Achilles tendon reflex Abdominal reflexes Romberg

Sensibility:

Blood test:
.....
.....

Urine test:

Chest X-ray:

ECG:

Ophthalmological examination:

Other examinations:

Summary of examination:

Conclusion:

Place Date Date

Signature of Institution's Medical Officer

Signature of examining doctor