# Medical History
## and
# Physical Examination
(To be completed by a physician)


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***Our mission is to empower people who are blind or visually impaired with lifelong skills for safe and independent daily travel.***

# Medical History

(To be completed by a health care professional)

Applicant Name _____

Applicant Address _____ City/St/Zip _____

1) Has the applicant had any of the following medical problems?

| | | | |
|---|---|---|---|
| Arthritis | Yes/No | Lung Disease | Yes/No |
| Emphysema | Yes/No | Asthma | Yes/No |
| Coughing Blood | Yes/No | Seizure/Epilepsy | Yes/No |
| Fainting Spells | Yes/No | Diabetes/Low Blood Sugar | Yes/No |
| Hearing Impairments | Yes/No | Ear Infections | Yes/No |
| Problems Sleeping | Yes/No | Nervous Disorder | Yes/No |
| Psychiatric Problems | Yes/No | Cancer | Yes/No |
| Heart Disease | Yes/No | Chest Pain | Yes/No |
| High Blood Pressure | Yes/No | Allergies of any kind | Yes/No |
| Head Trauma | Yes/No | Incontinence | Yes/No |

2) Surgery or Hospitalization for any reason (please explain) _____

_____

3) Serious Injuries or Accidents _____

4) History of Seizure or Epilepsy (please explain) _____

Approx. date of last seizure _____ Severity _____ Frequency _____

Duration of seizure _____ Can applicant detect seizure? _____

Has applicant been hospitalized due to seizure? _____

Has seizure medication been checked? _____ Is it normal? _____

5) List any allergies _____

6) DOCTOR'S COMMENTS—Give details to any item checked 'YES' from above list *(Please print)*

_____

_____

_____

_____

Signature _____, M.D./D.O. Date _____

# Physical Examination

(To be completed by your health care professional)

Applicant Name _____

7) **Current Health Conditions** _____

_____

_____

Height _____ Weight _____

Cause of Blindness _____

8) Hearing Test: Note in FEET how far from the applicant you were when testing for:

Spoken word _____ Right _____ Left _____

Whispered word _____ Right _____ Left _____

9) Does applicant wear hearing aids? ☐ Yes ☐ No

If yes, type ☐ BTE ☐ ITE ☐ EG ☐ CROS ☐ BI CROS

Is Aid T-coil equipped: ☐ Yes ☐ No

10) Sound localization intact? ☐ Yes ☐ No

Does applicant move head to localize? ☐ Yes ☐ No

**11) If applicant has hearing loss, please include or forward recent audiometric data.**

COMMENTS _____

_____

12) **In your opinion, can the applicant walk at a reasonable pace for ½ hour or more MULTIPLE times PER DAY without jeopardizing any current health problems?** ☐ Yes ☐ No

13) List any impairment of the use of either arm/hand _____

14) List any impairment of the use of either leg/foot _____

15) List any cognitive, emotional, behavioral or psychological limitations _____

_____

_____

Signature: _____ M.D./D.O. Date _____

# Medication Form

## Supplement to Application for Leader Dog Training

(To be completed by your health care professional)

Applicant Name _____

16) Please list all medications being taken:

| Medication | Dosage | Condition / Illness | Special Instructions |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

17) Please indicate any current or anticipated surgery and/or radical treatment _____

_____

_____

18) Can applicant inject own insulin? ☐ Yes ☐ No

19) Can applicant test own sugar level? ☐ Yes ☐ No Method Used _____

20) Is applicant aware of impending hypoglycemic episodes? ☐ Yes ☐ No

21) List any special dietary requirements _____

22) Does applicant smoke? ☐ Yes ☐ No

23) Applicant has been a patient since _____

24) Date of last previous physical exam _____

Signature _____ M.D./D.O. Date _____

**PLEASE TYPE OR PRINT**

Name _____

Address _____

City/St/Zip _____

Phone (_____)_____