

# MEDICAL FORM

This form to be completed by a Qualified Doctor



SOUTH AFRICAN GUIDE-DOGS  
association for the blind

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## CONFIDENTIAL MEDICAL REPORT

**Applicants Details:** (Doctors details to be furnished on page 5)

1. Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. VISION

What is the cause of blindness? \_\_\_\_\_

How long has applicant been blind? \_\_\_\_\_

Is the degree of blindness total or partial? \_\_\_\_\_

If partial, what is the degree of vision? \_\_\_\_\_

L E / 60

R E / 60

Can applicant distinguish day and night? \_\_\_\_\_

Can applicant see shadows? \_\_\_\_\_

Is there a field restriction? \_\_\_\_\_

3. HEARING

Is hearing in any way impaired? \_\_\_\_\_

Left ear \_\_\_\_\_

Right ear \_\_\_\_\_

If audiogram is available, please attach

4. Has applicant at any stage suffered from :

a) Palpitations, Chest pain, shortness of breath, ankle swelling or any heart complaint?  
\_\_\_\_\_

b) Chronic cough, pleurisy, asthma, or any lung complaint? \_\_\_\_\_

c) Rheumatism, gout, arthritis, bunions or any other join complaint?  
\_\_\_\_\_

d) Fits of any kind, attacks or unconsciousness.  
Any mental or nervous disorders? \_\_\_\_\_

e) Varicose veins, have they or are they likely to cause ulceration?  
\_\_\_\_\_

f) Recurrent incapacitation due to any other cause? \_\_\_\_\_  
\_\_\_\_\_

g) Has applicant had any surgery? Please submit nature of disability, when and where occurred and names of Doctors who treated.  
\_\_\_\_\_  
\_\_\_\_\_

h) Has weight altered in the last 3 years? \_\_\_\_\_

5. EXAMINATION

I. a) Height \_\_\_\_\_ Weight \_\_\_\_\_

b) Chest Expiration \_\_\_\_\_ cms

Inspiration \_\_\_\_\_ cms

c) Abdomen \_\_\_\_\_ cms

d) What is applicant's general physique \_\_\_\_\_

II a) Is breathing normal and regular in character? \_\_\_\_\_

\_\_\_\_\_

b) Is there any abnormality of the respiratory system to palpitation, percussion or auscultation? If so, give particulars

\_\_\_\_\_

\_\_\_\_\_

c) Is there any sign of past or present respiratory diseases?

\_\_\_\_\_

III a) What is rate of pulse? \_\_\_\_\_

Is pulse regular? \_\_\_\_\_

b) What is position of apex beat? \_\_\_\_\_

c) Describe heart sound, are any murmurs present? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

d) What is blood pressure? \_\_\_\_\_

e) Do you consider vascular system to be healthy? \_\_\_\_\_

If necessary perform exercise tolerance test.

\_\_\_\_\_

IV Are there any signs of disease of nervous or muscular systems?

\_\_\_\_\_

\_\_\_\_\_

V Urine \_\_\_\_\_ SG \_\_\_\_\_ ALB \_\_\_\_\_ SUGAR \_\_\_\_\_

6. TO BE FILLED IN IF APPLICANT HAS DIABETES

Duration of diabetes \_\_\_\_\_

Is diabetes under treatment or controlled? \_\_\_\_\_

Stable \_\_\_\_\_ Brittle \_\_\_\_\_

No of insulin injections \_\_\_\_\_ Type \_\_\_\_\_ Dosage \_\_\_\_\_

Does insulin requirement vary frequently? \_\_\_\_\_

Has patient ever been in insulin shock? \_\_\_\_\_

If so, how frequently? \_\_\_\_\_

Is patient aware of oncoming insulin shock? \_\_\_\_\_

Has patient ever been in a diabetic coma? \_\_\_\_\_

Does patient spill sugar in urine? \_\_\_\_\_

If so, how much and how often? \_\_\_\_\_

Heart \_\_\_\_\_ Edema \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Angina or other cardiac symptoms? \_\_\_\_\_

Intermittent claudication? \_\_\_\_\_

Walk tolerance (Distance without pain) \_\_\_\_\_

ECG (if available) \_\_\_\_\_

Respiration \_\_\_\_\_ At rest \_\_\_\_\_ Dyspnea \_\_\_\_\_

After exer. \_\_\_\_\_

Blood urea nitrogen or non-prot nitrogen (if available) \_\_\_\_\_

Urinalysis: Specific Gravity \_\_\_\_\_ Albumin \_\_\_\_\_

Sugar \_\_\_\_\_ Microscopic \_\_\_\_\_

FEET: Dorsalis Pedis ( \_\_\_\_\_  
( \_\_\_\_\_  
( Pulses (Present or absent)  
( \_\_\_\_\_  
Post Tibial ( \_\_\_\_\_

Knee jerks \_\_\_\_\_

Ankle jerks \_\_\_\_\_

Vibratory sensation in legs \_\_\_\_\_

Diabetic diet \_\_\_\_\_

Remarks \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. **MOST IMPORTANT**

The applicant will be required to walk up to 7 kilometers a day at a very brisk pace. The training continues non-stop for three weeks. Do you consider applicant capable of this high degree of exercise? Please comment on the general fitness of the applicant.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical Examiners Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone No \_\_\_\_\_