



## PERSATUAN DAYBREAK

### HEALTH ASSESSMENT FORM To Be Filled Out By A Medical Practitioner Only

|                      |   |  |       |   |  |
|----------------------|---|--|-------|---|--|
| Applicant's Name     | : |  | NRIC  | : |  |
| Medical Practitioner | : |  | Phone | : |  |
| Address              | : |  |       |   |  |
|                      |   |  |       |   |  |
|                      |   |  |       |   |  |

Persatuan DAYBREAK is a voluntary organization aimed at providing vocational skills training & job opportunities for the disabled to make them a functional member of the society.

Thank you for completing this form. This form will be considered in a confidential manner by Persatuan DAYBREAK.

As your patient is looking for vocational skills training at Persatuan DAYBREAK, we require this health assessment report for intake review.

**IT IS THE APPLICANTS RESPONSIBILITY TO ARRANGE THIS ASSESSMENT AND TO PAY ANY ASSOCIATED COST.**

LOT 75242 Jalan Pulai, RPT Pengkalan Pegoh, 31500 Lahat, Perak.  
Tel: 05-3235908 / 3235909 Fax: 05-3235910  
Email: [dbreak03@streamyx.com](mailto:dbreak03@streamyx.com)

## MEDICAL HISTORY

### MAJOR DISABILITIES ( Please tick where appropriate)

|                           |                                       |   |                                   |
|---------------------------|---------------------------------------|---|-----------------------------------|
| 1. Physically Disabled    | <input type="checkbox"/> No           | <input type="checkbox"/> Hemiplegia         |                                   |
|                           | <input type="checkbox"/> Quadriplegia | <input type="checkbox"/> Paraplegia         |                                   |
| Others. Please specify :  |                                       |   |                                   |
|                           |                                       |   |                                   |
| 2. Cerebral Palsy         | <input type="checkbox"/> No           | <input type="checkbox"/> Yes                |                                   |
| 3. Hearing                | <input type="checkbox"/> Normal       | <input type="checkbox"/> Partially Impaired | <input type="checkbox"/> Deaf     |
| 4. Vision                 | <input type="checkbox"/> Normal       | <input type="checkbox"/> Partially Impaired | <input type="checkbox"/> Blind    |
| 5. Mentally Handicapped   | <input type="checkbox"/> No           | <input type="checkbox"/> Yes                |                                   |
| Degree Of Mental Handicap | <input type="checkbox"/> Mild         | <input type="checkbox"/> Moderate           | <input type="checkbox"/> Profound |
|                           | <input type="checkbox"/> Severe       | <input type="checkbox"/> Unknown            |                                   |
| Cause :                   |                                       | Age of onset :                              |                                   |
|                           |                                       |   |                                   |
|                           |                                       |   |                                   |

### Does the applicant have a history of the following?

|  |  |
|--|--|
| 1. <input type="checkbox"/> Heart disease, Angina, High Blood Pressure | 7. <input type="checkbox"/> Hernia                       |
| 2. <input type="checkbox"/> Asthma, Other chronic chest conditions     | 8. <input type="checkbox"/> Anaemia                      |
| 3. <input type="checkbox"/> Chronic ear                                | 9. <input type="checkbox"/> Knee or other joint problems |
| 4. <input type="checkbox"/> Eczema / Dermatitis                        | 10. <input type="checkbox"/> Regular migraine headaches  |
| 5. <input type="checkbox"/> Muscular, Tendon or Ligament problems      | 11. <input type="checkbox"/> Arthritis                   |
| 6. <input type="checkbox"/> Diabetes                                   | 12. <input type="checkbox"/> Sciatica / Back pain        |
| Comments :   |  |
|  |  |
|  |  |

|                               |        |
|-------------------------------|--------|
| Previous Operations if any? : |        |
|                               | Date : |
|                               | Date : |
|                               |        |

### Are the following used?

|   |                                      |                                    |
|---|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Glasses / contact lenses | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Pacemaker |
| Comments :  |                                      |                                    |
|   |                                      |                                    |
|   |                                      |                                    |

| <b>EPILEPSY</b>  |  |                                       |                                       |
|--|--|---------------------------------------|---------------------------------------|
| Type of seizure  | <input type="checkbox"/> Generalised           | <input type="checkbox"/> Tonic Clonic | <input type="checkbox"/> Myoclonic    |
|  | <input type="checkbox"/> Absence               | <input type="checkbox"/> Partial      | <input type="checkbox"/> Simple       |
|  | <input type="checkbox"/> Complex               | <input type="checkbox"/> Other :      |                                       |
| Nature of seizures   | <input type="checkbox"/> Falling               | <input type="checkbox"/> Convulsion   | <input type="checkbox"/> Incontinence |
|  | <input type="checkbox"/> Aggression            | <input type="checkbox"/> Automatism   | <input type="checkbox"/> Diurnal      |
|  | <input type="checkbox"/> Loss of consciousness |                                       | <input type="checkbox"/> Nocturnal    |
| Warning  | <input type="checkbox"/> Yes                   |                                       | <input type="checkbox"/> No           |
| Nature of warning :  |  |                                       |                                       |
| Duration of seizure :  |  |                                       |                                       |
| Period of incapacity for work following seizure :  |  |                                       |                                       |
| Number & frequency of seizures during the past 12 months :                                     |  |                                       |                                       |
| When was the last seizure ? Approximately :  |  |                                       |                                       |
| Is it a temporary or long term condition? :  |  |                                       |                                       |
| Is the applicant stabilized on drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                       |                                       |

| <b>MEDICAL EXAMINATION</b>                               |                                   |  |  |
|--|-----------------------------------|--|--|
| Does the applicant have any problems with the following? |                                   |  |  |
| 1. <input type="checkbox"/> Head, Face, Neck, Scalp      | 5. <input type="checkbox"/> Eyes  | 09. <input type="checkbox"/> Chest / Lungs   |  |
| 2. <input type="checkbox"/> Mouth, Throat                | 6. <input type="checkbox"/> Back  | 10. <input type="checkbox"/> Nervous system  |  |
| 3. <input type="checkbox"/> Speech                       | 7. <input type="checkbox"/> Gait  | 11. <input type="checkbox"/> Upper extremity |  |
| 4. <input type="checkbox"/> Ears ( including drums )     | 8. <input type="checkbox"/> Heart | 12. <input type="checkbox"/> Lower extremity |  |
| Please number & comment on the above :                   |                                   |  |  |
|  |                                   |  |  |
|  |                                   |  |  |
|  |                                   |  |  |

| <b>PSYCHIATRIC / PSYCHOLOGICAL CONDITION</b> (Please circle appropriate condition)       |         |
|--|---------|
| Specialist Name :  | Phone : |
| Treatment clinic :   |         |
| Psychiatric / Psychological diagnosis :  |         |
| Is the condition stabilized ? : <input type="checkbox"/> Yes <input type="checkbox"/> No |         |
| Treatment Received :   |         |
|  |         |

| <b>CURRENT MEDICATION</b> |        |
|---------------------------|--------|
| Name                      | Dosage |
|                           |        |
|                           |        |
|                           |        |
|                           |        |

