



# PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL  
DETAILS IN BLOCK CAPITALS

Surname		Forenames		Address		Home telephone number	
		ISMAIL MOHAMMED		111078816 - TRUCKDRIVER		96267754	
Place of examination: MUSCAT		Date: 4/4/22					
If a dependant enter employee's name here: Surname:				Forenames:			
Birth date: 11/3/81		Nationality: INDIAN		Country of birth: INDIA		Religion: MUSLIM	
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input checked="" type="checkbox"/> Daughter		Number of children: 1	
Reason for examination		Pre-Employment <input type="checkbox"/> Periodic medical check-up <input checked="" type="checkbox"/>		Job: MECH. HELPER		Area:	
Pre-Overseas <input type="checkbox"/>							
Name and address of family doctor				List your last 3 jobs			
				(1)			
				(2)			
				(3)			
Are you a Registered Disabled Person? (UK only) <input type="checkbox"/>				Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>			
DO YOU HAVE OR HAVE YOU HAD:- (Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)							
Y		N		Y		N	
1. Sinus trouble				21. Cancer			
2. Neck swelling/glands				22. Heart Disease			
3. Difficulty in vision				23. Rheumatic fever			
4. Any ear discharge				24. Abnormal heartbeat			
5. Asthma/bronchitis				25. High blood pressure			
6. Hayfever /other significant allergy				26. Stroke			
7. Any skin trouble				27. Serious chest pain			
8. Tuberculosis				28. Any blood disease			
9. Shortness of breath				29. Kidney disease			
10. Coughed/vomited blood				30. Blood in urine			
11. Severe abdominal pain				31. Painful passage of urine			
12. Stomach ulcer				32. Diabetes			
13. Recurrent indigestion				33. Headaches/migraine			
14. Jaundice or hepatitis				34. Dizziness/fainting			
15. Gall Bladder disease				35. Epilepsy			
16. Marked change in bowel habits				36. Joints/spinal trouble			
17. Blood in stools (motions)				37. Surgical operation			
18. Marked change in weight				38. Serious accident/fracture			
19. Varicose veins				39. Tropical disease			
20. Lump in breast/ampit				40. Fear of heights			
How much tobacco each day? NO				Average daily alcohol consumption NO			
Have you ever taken elicited drugs? ( )							
FAMILY HISTORY: Diabetes ( ) Tuberculosis ( ) Epilepsy ( ) Asthma ( ) Eczema ( ) Heart disease ( ) High blood pressure ( ) Stroke ( ) Blood Disease ( ) Cancer ( )							
PLEASE READ THE FOLLOWING STATEMENT AND IF YOU AGREE KINDLY SIGN IT:-							
I declared these statements to be true to the best of my knowledge and belief and I agree that the result of this medical examination in general terms may be revealed to the Company if required, and the details sent to my own doctor if this is considered necessary by the examining medical officer.							
Date: 4/4/2022				Signature of Applicant: K. T. M. M. I.			





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FOR COMPLETION BY EXAMINING DOCTOR OR NURSE  
Further details of medical history and recreational activities

N = Normal A = Abnormal (please describe)		PHYSICAL EXAMINATION						
N	A							
✓		1. Eyes & Pupils						
✓		2. E.N.T.						
✓		3. Teeth & Mouth						
✓		4. Lungs & Chest						
✓		5. Cardiovascular System						
✓		6. Abdo. Viscera						
✓		7. Hernial Orifices						
		8. Anus & Rectum						
✓		9. Genito-urinary						
✓		10. Extremities						
✓		11. Musculo-skeletal						
✓		12. Skin & Varicose Vns.						
✓		13. C.N.S.						
		14. Breast						
HEIGHT cm	WEIGHT kg	BMI	B.P.	PULSE	HEARING	VISION	Colour Vision	Blood Group
166	54	19.6	122/87	73 mins.	L N R	DISTANT R L R L Uncorrected 6/6 6/6 Corrected	N	
N	A	LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A			
✓		1. Urinalysis		✓		7. Audiogram		
✓		2. Hb, Bloodcount, ESR		✓		8. Lung Function		
✓		3. LFT, RFT, RBS				9. Chest X-Ray		
		4. Drug Screen		✓		10. ECG		
✓		5. Lipids (40 years +)		3-9		11. CVS risk for 40 yrs. & above		
✓		6. Sickie Cell test				12. HIV, Hepatitis screening		

OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)

## ASSESSMENT:

☒ FIT ALL AREAS ☐ FIT WITH RESTRICTION ☐ TEMPORARY UNFIT ☐ UNFIT

Date: 4/4/22 Name (Block Capitals): Dr. / Nurse

Signature:

## REVIEW/CONSULTATION

Date: Name (Block Capitals): Dr. / Nurse

Signature:

