



## PEACE LAND MEDICAL CENTER



## MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

		Surname																																																																	
		Forenames ISMAIL MOHAMMED																																																																	
		Address 111078816 - TRUCK OMAN																																																																	
		Home telephone number 96867754																																																																	
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																																																																	
Pre-Overseas <input type="checkbox"/>		Area:																																																																	
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.)																																																																			
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How much tobacco each day? NO		Average daily alcohol consumption NO																																																																	
Have you ever taken elicited drugs? ( )																																																																			
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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: 11/4/2022		Signature of Applicant: <i>K. T. M. P.</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 73 mins.	HEARING L R	VISION DISTANT R L R L Uncorrected 6/6 6/6 Corrected					Colour Vision N	Blood Group	
166	54	19.6	122 87		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 +)								11. CVS risk for 40 yrs. & above				
✓	6. Sickle 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: 14/12/2018 Name (Block Capitals): Dr. / Nurse

Signature:

### REVIEW/CONSULTATION

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

Signature:

