



PEACE LAND MEDICAL CENTER



MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination MUSCAT		Date 10/10/21	Surname BHAVIN PRATAPSINGH																																																																																																														
If a dependant enter employee's name here:		Forenames BHAVIN PRATAPSINGH			Address 114083665 - Truk OMAN																																																																																																												
Surname:		Forenames:			Home telephone number 94026393																																																																																																												
Birth date: 11/01/88		Nationality: INDIAN	Country of birth: INDIA	Religion: HINDU																																																																																																													
<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced	<input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter	Relationship to employee																																																																																																													
Reason for examination		Pre-Employment <input type="checkbox"/> Periodic medical check-up <input type="checkbox"/>	Number of children: 0																																																																																																														
		Pre-Overseas <input type="checkbox"/>	Job: MECHANIC																																																																																																														
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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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: 10/10/21		Signature of Applicant:																																																																																																															



PEACE LAND MEDICAL CENTER

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											
<input checked="" type="checkbox"/>	1. Eyes & Pupils											
<input checked="" type="checkbox"/>	2. E.N.T.											
<input checked="" type="checkbox"/>	3. Teeth & Mouth											
<input checked="" type="checkbox"/>	4. Lungs & Chest											
<input checked="" type="checkbox"/>	5. Cardiovascular System											
<input checked="" type="checkbox"/>	6. Abdo. Viscera											
<input checked="" type="checkbox"/>	7. Hernial Orifices											
<input checked="" type="checkbox"/>	8. Anus & Rectum											
<input checked="" type="checkbox"/>	9. Genito-urinary											
<input checked="" type="checkbox"/>	10. Extremities											
<input checked="" type="checkbox"/>	11. Musculo-skeletal											
<input checked="" type="checkbox"/>	12. Skin & Varicose Vns.											
<input checked="" type="checkbox"/>	13. C.N.S.											
<input checked="" type="checkbox"/>	14. Breast											
HEIGHT cm		WEIGHT kg	BMI	B.P (MMHG)	PULSE /mins.	HEARING L R	VISION				Colour Vision	Blood Group
158		61	24.4	138 80	65	R ~ L	DISTANT R L	NEAR R L				
N A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS				N	A					
<input checked="" type="checkbox"/>	1. Urinalysis				<input checked="" type="checkbox"/>	7. Audiogram						
<input checked="" type="checkbox"/>	2. Hb, Bloodcount, ESR				<input checked="" type="checkbox"/>	8. Lung Function						
<input checked="" type="checkbox"/>	3. LFT, RFT, RBS				<input checked="" type="checkbox"/>	9. Chest X-Ray						
<input checked="" type="checkbox"/>	4. Drug Screen				<input checked="" type="checkbox"/>	10. ECG						
<input checked="" type="checkbox"/>	5. Lipids (40 years +)				<input checked="" type="checkbox"/>	11. CVS risk for 40 yrs. & above						
<input checked="" type="checkbox"/>	6. Sickle Cell test				<input checked="" type="checkbox"/>	12. HIV, Hepatitis screening						
OTHER FINDINGS (Physique, scars, disabilities, mental stability including behaviour, etc.)												
ASSESSMENT:												
<input checked="" type="checkbox"/> FIT ALL AREAS		<input type="checkbox"/> FIT WITH RESTRICTION		<input type="checkbox"/> TEMPORARY UNFIT		<input type="checkbox"/> UNFIT						
Date: 12/10/2021		Name (Block Capitals): Dr. / Nurse:		Signature:								
REVIEW/CONSULTATION												
Date:		Name (Block Capitals): Dr. / Nurse		Signature:								

