



PEACE LAND MEDICAL CENTER

MEDICAL EXAMINATION REPORT (CONFIDENTIAL)

PLEASE COMPLETE YOUR PERSONAL DETAILS IN BLOCK CAPITALS

Place of examination **mus** Date **27/6/21**

If a dependant enter employee's name here:

Surname:

Birth date: **3/4/60**

Nationality: **Indian**

Male Female

Married Single Separated /Divorced

Wife Son Daughter

Relationship to employee
Number of children:

Reason for examination

Pre-Employment

Periodic medical check-up

Job:

Pre-Overseas

Driver

Name and address of family doctor

List your last 3 jobs

(1)

(2)

(3)

Are you a Registered Disabled Person? (UK only)

Do you belong to any Medical Insurance Scheme?

DO YOU HAVE OR HAVE YOU HAD:-

(Tick "Yes" or "No" column or put a (?) if uncertain exclude minor ailments.)

	Y	N		Y	N		Y	N
1. Sinus trouble			21. Cancer			HAVE YOU EVER BEEN:-		
2. Neck swelling/glands			22. Heart Disease			41. Rejected for employment or insurance for medical reasons		
3. Difficulty in vision			23. Rheumatic fever			42. Awarded benefits for industrial injury/illness		
4. Any ear discharge			24. Abnormal heartbeat			43. Treated for a mental condition, e.g. depression		
5. Asthma/bronchitis			25. High blood pressure			44. Treated for problem drinking or drug abuse		
6. Hayfever /other significant allergy			26. Stroke			45. Exposed to toxic substance or noise		
7. Any skin trouble			27. Serious chest pain			FOR WOMEN ONLY		
8. Tuberculosis			28. Any blood disease			Have you ever had:-		
9. Shortness of breath			29. Kidney disease			46. An abnormal smear		
10. Coughed/vomited blood			30. Blood in urine			47. Any gynaecological treatment		
11. Severe abdominal pain			31. Painful passage of urine			48. Are you pregnant?		
12. Stomach ulcer			32. Diabetes			49. HAVE YOU HAD AN ILLNESS NOT MENTIONED ABOVE		
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/armpit			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:

27/6/21

Signature of Applicant:

P. Prajapati

Surname **KUMAR**
Forenames **RAJAPATI HARESH**
Address **115440271 - Tawil, Oman**
Home telephone number **96788211**

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														
/		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. 108 89	PULSE 89/mins.	HEARING L N R	VISION DISTANT R L NEAR R L				Colour Vision	Blood Group			
162	66	25-1				Uncorrected Corrected	6/6	6/6			N				
N	A				LABORATORY AND OTHER SPECIAL INVESTIGATIONS			N	A						
/		1. Urinalysis			PTG 5			/		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 +)									11.27		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.)

Adm.: Diet control, regular exercise & follow up.

ASSESSMENT:

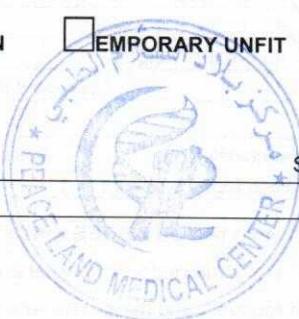
FIT ALL AREAS

FIT WITH RESTRICTION

TEMPORARY UNFIT

UNFIT

Date: 28/6/2021 Name (Block Capitals): Dr. / Nurse



Signature:



REVIEW/CONSULTATION

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

Signature: