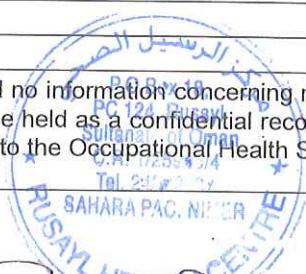


ROUTINE/PERIODIC EXAMINATION REPORT (MEDICAL- CONFIDENTIAL)



Mobile No. 96740666		Surname/ Forenames SURESH RAMKISHUN YADAV	
		Nationality INDIAN	
Home/Leave Address:		Company Number: 1.D - 115948694	
Personal Details		Age - 35 yrs, I.D - 115948694	
A <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		<input checked="" type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated /Divorced /Widow(er)	
Home/Leave Address:		Relationship to employee <input type="checkbox"/> Wife <input type="checkbox"/> Son <input type="checkbox"/> Daughter No of Children: 1	
Reason for Examination (tick as appropriate)			
Periodic Medical Examination <input checked="" type="checkbox"/>		Final / Retirement <input type="checkbox"/> Other Reason: <input type="checkbox"/>	
Employee only			
B Present Job and Location: Forklift Operator/Driver		Next Job and Location: Driver/Truck Driver	
Are you a registered person with special needs? <input type="checkbox"/>		Do you belong to any Medical Insurance Scheme? <input type="checkbox"/>	
<p>Previous Medical History: All important medical events should be listed and dated at every medical examination. To be completed together with the interviewing Nurses or Doctor who will be able to help by referring to your notes.</p> <p>Please answer the following questions and tick 'N' (no) or 'Y' (yes) in the column. If 'Y' Please describe</p>			
		N	Y
Have you, since your last medical been treated by your family doctor or specialist for significant (major) ailments?			
1	Ear, nose, eye or throat problems		
2	Chest problems like asthma, bronchitis, other bad cough		
3	Heart abnormality, chest pains		
4	Abdominal pains, abnormal bowel motions		
5	Urogenital problems (kidney disease, menstrual disorder)		
6	Skin trouble or allergies		
7	Epileptic fits, dizzy spells or migraine		
8	History of mental illness, depression anxiety		
9	Diabetes, thyroid disease		
10	Blood disorder e.g. anaemia, blood cancer e.g. leukaemia		
11	Any history of accidents or fractures		
12	Have you had any serious allergies		
13	Do any dependants have a significant ongoing illness?		
14	Any family history of cancers		
Do you take any regular medicines, or have you taken in the past?			
Do you smoke? If yes, what and how much each day?			
Do you drink alcohol? If yes, what is your average weekly intake?			
Have you ever taken elicited/recreational drugs?			
Are you doing regular sports or physical activities? <input checked="" type="checkbox"/>			

STATEMENT: I have read the above questions and the above answers are correct and no information concerning my present or past state of health has been withheld. I understand and agree that this form will be held as a confidential record by PDO Medical Department, and may be copied (by paper or secure electronic transmission) to the Occupational Health Services for the purpose of Health Surveillance and other Occupational Health review.



Date: 22/10/22

Signature of Applicant: SURESH YADAV

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.

HEIGHT cm	WEIGHT kg	BMI	B.P. 110 70 mmHg	PULSE 92/mins.	HEARING L M R N	VISION	
						DISTANT	NEAR
167	74	26.5				R 6/6	R L 6/6

N	A		LABORATORY AND OTHER SPECIAL INVESTIGATIONS		N	A	
✓		1. Urinalysis	FBS - 80 mg/dl		✓		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 AND RECOMMENDATIONS:

FIT ALL AREAS FIT WITH RESTRICTION TEMPORARY UNFIT UNFIT

Date: 22/10/22

Name (Block Capitals): Dr. / Nurse



REVIEW/CONSULTATION

Date:

Name (Block Capitals): Dr. / Nurse

Signature:

